



Independent Laboratory

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General Information

Introduction

The Virginia Medicaid Provider Manual describes the role of the provider in the Virginia Medical Assistance Program (Medicaid). To provide a better understanding of the Medicaid Program, this manual explains Medicaid rules, regulations, procedures, and reimbursement and contains information to assist the provider in answering inquiries from Medicaid members.

The manual can also be an effective training and reference tool for provider administrative personnel, since it conveys basic information regarding the Medicaid Program, covered and non-covered services, and billing procedures. Proper use of the manual will result in a reduction of errors in claims filing and, consequently, will facilitate accurate and timely payment.

In addition to the Medicaid Program, other programs administered by the Department of Medical Assistance Services (DMAS) include the Family Access to Medical Insurance Security (FAMIS) program, the State and Local Hospitalization (SLH) program, and the Uninsured Medical Catastrophe Fund. If you have any questions concerning the Medicaid Program or any of the other programs listed above, please contact the provider "HELPLINE" at:

804-786-6273 Richmond Area

1-800-552-8627 All other areas

Program Background

In 1965, Congress created the Medical Assistance Program as Title XIX of the Social Security Act, which provides for federal grants to the states for their individual Medical

Assistance programs. Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965. This enactment is popularly called "Medicaid" but is officially entitled "Grants to States for Medical Assistance Programs." The purpose of Title XIX is to enable the states to provide medical assistance to eligible indigent persons and to help these individuals if their income and resources are insufficient to meet the costs of necessary medical services. Such persons include dependent children, the aged, the blind, the disabled, pregnant women, and needy children.

The Medicaid Program is a jointly administered federal/state program that provides payment for necessary medical services to eligible persons who are unable to pay for such services. Funding for the Program comes from both the federal and state governments. The amount of federal funds for each state is determined by the average per capita income of the state as compared to other states.

Virginia's Medical Assistance Program was authorized by the General Assembly in 1966 and is administered by the Virginia Department of Medical Assistance Services (DMAS). The Code of Federal Regulations allows states flexibility in designing their own medical assistance programs within established guidelines. Virginia Medicaid's goal is to provide health and medical care for the Commonwealth's poor and needy citizens using the health care delivery system already in place within the state. In 2003, the Virginia General Assembly changed the name of the Medicaid program covering most children to FAMIS Plus. The change in name was intended to facilitate a coordinated program for children's health coverage including both the FAMIS (Family Access to Medical Insurance Security Plan) and FAMIS Plus programs. All covered services and administrative processes for children covered by FAMIS Plus remain the same as in Medicaid. While the Virginia Medicaid Program is administered by DMAS, the eligibility determination process is performed by local departments of social services through an interagency agreement with the Virginia Department of Social Services. The *State Plan for Medical Assistance* for administering the Medicaid Program was developed under the guidance of the Advisory Committee on Medicare and Medicaid appointed by the Governor of the Commonwealth of Virginia. The State Plan is maintained through continued guidance from the Board of Medical Assistance Services, which approves amendments to the *State Plan for Medical Assistance* with policy support from the Governor's Advisory Committee on Medicare and Medicaid. Members of the Governor's Advisory Committee and the Board of Medical Assistance Services are appointed by the Governor.

Individuals originally became eligible for Medicaid because of their "categorical" relationship to two federal cash assistance programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). However, congressional mandates in the late 1980s resulted in dramatic changes in Medicaid eligibility provisions. Now individuals, in additional selected low-income groups, are eligible for Medicaid solely on the relationship of their incomes to the Federal Poverty Guidelines. New Federal Poverty Guidelines are published annually in the *Federal Register* and become effective upon publication.

On June 7, 2018, Governor Northam approved the state budget that expanded eligibility to include the Modified Adjusted Gross Income (MAGI) adult group, also known as the Medicaid Expansion covered group. The MAGI adult group includes adults between the ages of 19 and 64, who are not eligible for or enrolled in Medicare, and who meet income eligibility rules. After receiving the necessary approvals from the Centers for Medicare and Medicaid Services (CMS), DMAS began enrolling individuals in the MAGI adult group on January 1, 2019.

Medicaid is a means-tested program. Applicants' income and other resources must be within program financial standards, and different standards apply to different population groups, with children and pregnant women, the MAGI adult group, and persons who are aged, blind, or disabled. Reference Chapter III of this manual for detailed information on groups eligible for Medicaid.

General Scope of the Program

The Medical Assistance Program (Medicaid) is designed to assist eligible members in securing medical care within the guidelines of specified State and federal regulations. Medicaid provides access to medically necessary services or procedures for eligible members. The determination of medical necessity may be made by the Utilization Review Committee in certain facilities, a peer review organization, DMAS professional staff or DMAS contractors.

Covered Services

The following services are provided, **with limitations** (certain of these limitations are set forth below), by the Virginia Medicaid Program:

- BabyCare - Prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two.
- Blood glucose monitors and test strips for pregnant women
- Case management services for high-risk pregnant women and children up to age 1

(as defined in the State Plan and subject to certain limitations)

- Christian Science sanatoria services
- Clinical psychology services
- Clinic services
- Community developmental disability services
- Contraceptive supplies, drugs and devices
- Dental services
- Diabetic test strips
- Durable medical equipment and supplies
- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) - For individuals under age 21, EPSDT must include the services listed below:
- Screening services, which encompass all of the following services:
 - Comprehensive health and developmental history
 - Comprehensive, unclothed physical exam
 - Appropriate immunizations according to age and health history
 - Laboratory tests (including blood lead screening)

- Health education
- Home health services
- Eyeglasses for all members younger than 21 years of age according to medical necessity
- Hearing services
- Inpatient psychiatric services for members under age 21
- Environmental investigations to determine the source of lead contamination for children with elevated blood lead levels
- Other medically necessary diagnostic and treatment services identified in an EPSDT screening exam, not limited to those covered services included above
- Skilled nursing facilities for persons under 21 years of age
- Transplant procedures as defined in the section “transplant services”
- All states are required to offer EPSDT to all Medicaid-eligible individuals under age 21 to determine any physical and mental defects that they may have and to provide health care, treatment, and other measures to correct or ameliorate the defects or chronic conditions discovered. The services available under EPSDT are not limited to those available in the Medicaid State Plan for Medical Assistance. Services requiring preauthorization under the State Plan for Medical Assistance will continue to require pre-authorization. DMAS reserves the right to utilize medical necessity

criteria for non-State Plan services under EPSDT.

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver services - Individuals who meet the criteria for a nursing facility level of care can be authorized to receive adult day health care, personal care (agency directed or consumer directed) services, Respite Care and Skilled Respite Care services, Personal Emergency Response

System (PERS), Services Facilitation services, Transition Coordination, and Transition services

- Emergency hospital services
- Emergency services for aliens
- Enteral nutrition (EN) - Coverage is limited to circumstances in which the nutritional supplement is the sole source of nutrition except for individuals authorized through the CCC Plus Waiver or through EPSDT, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of oral administration does NOT include the provision of routine infant formula.
- Extended services for pregnant women, pregnancy-related and postpartum services for 60 days after the pregnancy ends (limitations applicable to all covered services apply to this group as to all other member groups)
- Eye refractions
- Plan First (family planning services) - Medicaid fee-for-service program for men and women who meet the eligibility criteria. Plan First includes coverage of those services necessary to prevent or delay a pregnancy. It shall not include services to

promote pregnancy such as infertility treatments. Family planning does not include counseling about, recommendations for or performance of abortions, or hysterectomies or procedures performed for medical reasons such as removal of intrauterine devices due to infections.

- Federally Qualified Health Center services
- Home and Community-Based Care Waiver services
- Home health services
- Hospice services for individuals certified as terminally ill (defined as having a medical prognosis that life expectancy is six months or less)
- Family and Individual Support Waiver
- Gender dysphoria treatment services
- Inpatient care hospital services
- Inpatient Psychiatric Hospital Services for Individuals under 21 years of age (medically needy are not covered)
- Intensive rehabilitation services
- Intermediate care facility – Individuals with Intellectual Disabilities Services (medically needy members are not covered)

- Laboratory and radiograph services

- Legend and Non-legend drugs are covered with some limitations or exclusions. (See the Pharmacy Manual for specific limitations and requirements)

- Mental health, with limitations, covered under mental health and intellectual disability community services listed below:

- Mental Health:
 - Crisis stabilization
 - Mental health support
 - Assertive community treatment
 - Intensive in-home services for children and adolescents
 - Therapeutic day treatment for children and adolescents
 - Partial hospitalization Program
 - Intensive Outpatient Program
 - Psychosocial rehabilitation
 - Crisis intervention
 - Case management

- Substance Use Disorder:
 - Residential treatment for pregnant and postpartum women
 - Day treatment for pregnant and postpartum women
 - Crisis Intervention
 - Intensive Outpatient
 - Day Treatment
 - Case Management
 - Opioid Treatment

- Outpatient Treatment
- Community Living Waiver:
 - Nurse-midwife services
 - Nursing facility services
- Occupational therapy
- “Organ and disease” panel test procedures for blood chemistry tests
- Optometry services
- Outpatient hospital services
- Over-the-counter alternatives to certain classes of legend drugs. Upon a doctor’s prescription or order, a pharmacy may provide and Medicaid will cover a drug that no longer requires a prescription to dispense. See the Pharmacy Manual for specific limitations and requirements.
- Papanicolaou smear (Pap) test
- Payment of deductible and coinsurance up to the Medicaid limit less any applicable payments for health care benefits paid in part by Title XVIII (Medicare) for services covered by Medicaid.
- Physician services

- Podiatry services
- Prostate specific antigen (PSA) test (1998)
- Prostheses limited to artificial arms, legs, and the items necessary for attaching the prostheses, which must be pre-authorized by the DMAS central office. Also breast prostheses for any medically necessary reason and ocular prostheses for reason for loss of eyeball regardless of age of the member or the cause of the loss of the eyeball.
- Psychiatric Hospitals for the Aged (65 Years and Older)
- Psychological testing for persons with intellectual disability as part of the evaluation prior to admission to a nursing facility (January 1, 1989)
- Reconstructive surgery - post-mastectomy (1998)
- Rehabilitation services (physical therapy - effective 1969; other rehabilitation services - effective 1986)
- Renal dialysis clinic services
- Routine preventive medical and dental exams and immunizations, sensory and developmental screenings and immunizations are covered for all eligible members under the age of 21
- Routine preventive and wellness services, including annual wellness exams, immunizations, smoking cessation, and nutritional counseling services for the MAGI

Adult (Medicaid Expansion) covered group.

- Rural Health Clinic services
- School-based services
- Services for individuals age 65 and older in institutions for mental diseases
- Specialized nursing facility services
- Speech-language therapy services
- CCC Plus Waiver services - For children and adults who are chronically ill or severely impaired, needing both a medical device to compensate for the loss of a vital body function and require substantial and ongoing skilled nursing care to avert further disability or to sustain their lives. Authorized services include Private Duty Nursing, Private Duty Respite Care services, Personal Care (Adults Only), Assistive Technology, Environmental Modifications and Transition services.
- Telemedicine for selected services.
- Tobacco Cessation screening, counseling and pharmacotherapies.
- Transplant services: kidney and corneal transplants, heart, lung, and liver transplants, without age limits; under EPSDT, liver, heart, lung, small bowel and bone marrow transplants and any other medically necessary transplant procedures that are not experimental or investigational, limited to persons under 21 years of age. Coverage of bone marrow transplants for individuals over 21 years of age is

allowed for a diagnosis of lymphoma or breast cancer, leukemia, or myeloma.

- Transportation services related to medical care
- Treatment Foster Care Case Management

General Exclusions

Payment cannot be made under the Medicaid Program for certain items and services, and Virginia Medicaid will not reimburse providers for these non-covered services. Members have been advised that they may be responsible for payment to providers for non-covered services. Prior to the provision of the service, the provider must advise the member that he or she may be billed for the non-covered service. The provider may not bill the member for missed or broken appointments, which includes transportation services arranged by the member who is not at the pickup point or declines to get into the vehicle when the provider arrives.

Examples of such non-covered services are as follows:

- Abortions, except when the life or health of the mother is substantially endangered
- Acupuncture
- Artificial insemination or in vitro fertilization
- Autopsy examinations
- Cosmetic surgery

- Courtesy calls - visits in which no identifiable medical service was rendered
- Custodial care
- DESI drugs (drugs considered to be less than effective by the Food and Drug Administration)
- Domestic services (except for those approved as part of personal care services or homemaker services under BabyCare or EPSDT)
- Experimental medical or surgical procedures
- Eyeglass services for members age 21 and over
- Fertility Services - Services to promote fertility are not covered. However, if there is a disease of the reproductive system that requires treatment to maintain overall health, the medical procedure will be covered
- Free services - Services provided free to the general public cannot be billed to Medicaid; this exclusion does not apply where items and services are furnished to an indigent individual without charge because of his or her inability to pay, provided the provider, physician, or supplier bills other patients to the extent that they are able to pay
- Items or services covered under a workers' compensation law or other payment sources
- Meals-on-Wheels or similar food service arrangements and domestic housekeeping

services which are unrelated to patient care

- Medical care provided by mail or telephone (not including telemedicine)
- Medical care provided in freestanding psychiatric hospitals except through EPSDT and SUD waiver, or for individuals aged 65 and over
- Personal comfort items
- Physician hospital services for non-covered hospital stays
- Private duty nursing services – Other than for children under an appropriate waiver or EPSDT and adults under the appropriate waiver
- Procedures prohibited by State or federal statute or regulations
- Prostheses (other than limbs, and the items necessary for attaching them, and breast prostheses)
- Psychological testing done for purposes of educational diagnosis or school admission or placement
- Routine foot care
- Screening services: Exceptions: Pap smears, mammograms, and PSA tests consistent with the guidelines published by the American Cancer Society.

- Services determined not to be reasonable and/or medically necessary
- Services to persons age 21 to 65 in mental hospitals
- Sterilizations when the patient is under age 21 or legally incompetent
- Supplies and equipment for personal comfort, such as adult diapers except when provided as durable medical equipment, "Lifecall" systems (except under the EDCD, DD, and Intellectual Disability Waivers), and air cleaners
- Unkept or broken appointments
- Unoccupied nursing facility beds except for therapeutic leave days for nursing facility patients
- Weight loss programs

MEMBER COPAYS

COPAYS ARE THE SAME FOR CATEGORICALLY NEEDY MEMBERS, QUALIFIED MEDICARE BENEFICIARIES (QMBS), AND MEDICALLY NEEDY MEMBERS. COPAYS AND THEIR AMOUNTS ARE EXPLAINED IN CHAPTER III OF THIS MANUAL.

Managed Care Programs

Coverage for the vast majority of Medicaid enrolled individuals is provided through one of the DMAS managed care programs, Medallion 4.0 or Commonwealth Coordinated Care Plus (CCC Plus). Medallion 4.0 and CCC Plus programs contract with the same six managed care organizations (MCOs), and all MCOs offer coverage statewide. In addition, both CCC Plus and Medallion 4.0 provide services that help keep people healthy as well as services that focus on improving health outcomes. For more information on the current health plans, please visit www.dmas.virginia.gov.

Medallion 4.0 serves as the delivery system for children, pregnant women, and individuals in

the MAGI Adult Group who are not determined to be “medically complex.” CCC Plus provides a higher acuity of care coordination services and serves as the delivery system that provides coverage for individuals who are aged, blind or disabled, or who are dually eligible for Medicare and Medicaid, or who receive long-term services and supports, or individuals in the MAGI adult group determined to be “medically complex.” “Medically complex” is defined as individuals who have complex medical and/or behavioral health condition and a functional impairment, or an intellectual or developmental disability.

Individuals awaiting managed care enrollment will receive coverage through the DMAS fee-for-service program for a brief period (approximately 15-45 days) until they are enrolled in managed care. Additionally, some services for managed care enrolled individuals are covered through fee-for-service; these are referred to as managed care carved-out services. Detailed information about managed care-excluded populations and carved out services for Medallion 4.0 and CCC Plus is available on the DMAS website at <http://www.dmas.virginia.gov>, under Managed Care Benefits.

Once enrolled in managed care, members have up to 90 days to change their plan for any reason. Members also have the ability to change their plan during their annual open enrollment period. Open enrollment varies by population and program. For the MAGI Adult (expansion) population, open enrollment is from November 1 through December 31 each year. For CCC Plus, open enrollment is from October 1 through December 18 each year. For Medallion 4.0 open enrollment varies by program region. (See Managed Care Enrollment Broker section below for additional information.)

Managed Care Enrollment Broker (Maximus)

DMAS contracts with an enrollment broker, Maximus, which provides information to help Medallion and CCC Plus members select or change health plans. Members can find out which health plans contract with their primary care provider (PCP) or other provider. Providers should also let their members know which Medicaid health plans they accept. Members may use the following Maximus contact information for the Medallion 4.0 and CCC Plus managed care programs.

- **Medallion 4.0**

Maximus has designed a mobile app for managed care enrollment for the Medallion 4.0 program. The app is available to download in the Apple App Store and Google Play for both iPhone and Android users.

To get the free mobile app, search for Virginia Managed Care on the Apple App Store

or Google Play and download. After downloading the app, members will log in using a two-step identification process, Medicaid ID, and social security number, or social security number and date of birth; non-members can log-in as guests.

Similar to the website, the main capabilities of the app allow members to view their profile, compare health plans, enroll in a health plan, change health plans, and search for providers and health plan information. For more information, members can also visit the Medallion 4.0 enrollment website at: <https://virginiamanagedcare.com/> or call 1-800-643-2273 or TTY: 1-800-817-6608.

- **CCC Plus**

Members can visit the enrollment website for the CCC Plus managed care program at <https://cccplusva.com/> to view the health plan comparison chart and to choose or change their health plan. Members can also call the CCC Plus Helpline at 1-834374-9159 or TTY 1-800-817-6608 for more information.

MCO Provider Reimbursement

In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan. The managed care plan may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for service individuals. For more information, please contact the individual's managed care plan directly. Providers interested in contracting with the plans should also contact the MCO directly. MCO contact information for contracting and credentialing is available on the DMAS website:

- **Medallion 4.0** The managed care helpline for the Medallion program is 800-6432273 and the web address is <https://www.virginiamanagedcare.com/>
- **CCC Plus** (<http://www.dmas.virginia.gov/#/cccplusinformation> See "Medical Provider Update October 2017")

DMAS reimburses the health plans a monthly capitated fee for each member. These fees are preset, and are determined by demographics such as patient's age, sex, program designation, and locality of residence. Each MCO is responsible for developing its own network of providers and for ensuring that its delivery system has an adequate number of facilities, locations, and personnel available and accessible to provide covered services for its members. Providers who contract with a MCO must meet the MCO's contracting requirements.

Medicaid-contracted MCOs must provide all the services covered by Medicaid, at least within an equal, amount, duration, and scope as Medicaid, except for certain “carved-out services.” “Carved-out” means that the client remains enrolled in the MCO plan but the carved-out services are covered and reimbursed by DMAS within DMAS program guidelines. **DMAS will NOT provide reimbursement for services provided to MCO enrolled members EXCEPT for those services carved-out specifically from the MCO contracts.** Carved-out services vary by program and are listed in the CCC Plus and Medallion 4.0 Contracts, available on the DMAS Website, in the Managed Care Benefits section. The member must present his or her Medicaid plastic ID card when receiving carved-out services.

Eligibility and MCO Enrollment Verification

Medicaid eligibility and managed care enrollment coverage must be verified before treatment is provided. Medallion and CCC Plus members will have a MCO identification card and a Medicaid card. Medallion and CCC Plus MCO providers must adhere to their contract with the MCO regarding referrals, prior authorization, and billing requirements. Service authorization from the member’s MCO is required for any out-of-network services, *except for emergency and family planning services*. The provider is responsible for ensuring that proper referrals and service authorizations are obtained. If the MCO denies authorization for a service, the member may exercise his right to appeal to the MCO. Members can also appeal to DMAS after first exhausting the MCO’s appeal process. A provider may bill a member only when the provider has provided advanced written notice to the member, prior to rendering services that their MCO/Medicaid will not pay for the service. The notice must also share that the provider is accepting the member as a private pay patient, not as a Medicaid patient and the services being provided are the financial responsibility of the patient. Failure to confirm Medicaid eligibility and MCO coverage can result in a denial of payment.

To verify eligibility, call the MCO’s enrollment verification system or the DMAS MediCall line at 1-800-772-9996 or 1-800-884-9730 (outside of Richmond), or (804) 965-9732 or (804) 965-9733 for Richmond and the surrounding counties. Eligibility information is also available using the web-based Automated Response System (ARS). When using the DMAS MediCall line or the ARS system, MCO information, if applicable, follows Medicaid eligibility information.

Continuity of Care

The Department attempts to make the transition between fee-for-service Medicaid and the MCO seamless whenever possible. As a result there is a process to ensure that the Medicaid information and authorization information is transferred and honored. In order to assure continuity of care for members enrolled in MCOs, the following procedures are used:

- The Member's MCO shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the MCO enrollment effective date, in the absence of a written agreement otherwise. For on-going services, such as home health, outpatient mental health, and outpatient rehabilitation therapies, etc., the member's MCO shall continue authorized services without interruption until the Contractor completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider;
- DMAS shall assume responsibility for all covered services authorized by the member's previous MCO which are rendered after the effective date of dis-enrollment to the fee-for-service system, if the member otherwise remains eligible for the service(s), and if the provider is a Medicaid provider;
- If the prior authorized service is an inpatient stay, the claim should be handled as follows:
 - o If the provider contracts with the MCO under a per diem payment methodology, the financial responsibility shall be allocated between the member's current MCO and either DMAS or the new MCO. In the absence

of a written agreement otherwise, the member's current MCO and DMAS or the new MCO shall each pay for the period during which the member is enrolled with the entity.

- o If the provider contracts with the MCO under a DRG payment methodology, the MCO is responsible for the full inpatient hospitalization from admission to discharge, including any outlier charges.
- If services have been authorized using a provider who is out of network, the member's MCO may elect to reauthorize (but not deny) those services using an in-network provider.

Family Access to Medical Insurance Security (FAMIS) Plan

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the

provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Virginia's Title XXI program is known as FAMIS and is a comprehensive health insurance program for Virginia's children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit and under 200 percent of the Federal Poverty Level. FAMIS is administered by DMAS and is funded by the state and federal government.

FAMIS Covered Services

FAMIS covered services are somewhat different from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are not eligible for EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO). Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;
 - Assistive technology
 - Blood lead testing
- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:
 - Intensive in-home services
 - Therapeutic day treatment
- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations

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- Disposable medical supplies
 - Early Intervention services including targeted case management
 - Emergency hospital services
 - Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives
 - Gender dysphoria treatment services
 - Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)
 - Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
 - Inpatient substance abuse treatment services, with the following exceptions: services furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services
 - Inpatient services (365 days per confinement; includes ancillary services)
 - Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services
 - Maternity services including routine prenatal care
 - Medical formula, enteral/medical foods (sole source, specialized formula - not routine infant formula)
 - Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations
 - Organ transplantation
 - Outpatient mental health services, other than services furnished in a state-operated mental hospital
 - Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, case management, and peer support services
 - Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician's office or outpatient hospital department
 - Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);
 - Prescription drugs (mandatory generic program) and over-the-counter (optional for managed care)
 - Peer support services
 - Physician services, including services while admitted in the hospital, or in a

physician's office, or outpatient hospital department

- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- School based health services
- Skilled nursing facility
- Surgical services
- Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)
- Vision services
- Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP)

Member Copays

FAMIS does not have yearly or monthly premiums. However, children who are enrolled in a MCO must pay co-payments for some covered services. There are no co-payments required for preventative services such as well-child care, immunizations, or dental care. The chart below shows the co-payment amounts for some basic FAMIS services for children who are enrolled in a MCO, based on co-pay status.

NOTE: Native Americans and Alaskan Natives do NOT have any co-payments.

SERVICE*	Co-pay Status 1	Co-pay Status 2
Outpatient Hospital or Doctor	\$2 per visit	\$5 per visit
Prescription Drugs	\$2 per prescription	\$5 per prescription
Inpatient Hospital	\$15 per admission	\$25 per admission
Non-emergency use of Emergency Room	\$10 per visit	\$25 per visit
Yearly Co-payment Limit per Family	\$180	\$350

*Other co-payments may apply to other services.

EMERGENCY MEDICAID SERVICES FOR ALIENS

Section 1903v of the Social Security Act (42 U.S.C. 1396b) requires Medicaid to cover emergency services for specified aliens when these services are provided in a hospital emergency room or inpatient hospital setting. (See Chapter III for details on eligibility.)

The medical conditions subject to this coverage may include, but are not limited to, the following:

- Cerebral vascular attacks
- Traumatic injuries
- Childbirth
- Acute coronary difficulties
- Emergency surgeries (i.e., appendectomies)
- Episodes of acute pain (etiology unknown)
- Acute infectious processes requiring intravenous antibiotics
- Fractures

To be covered, the services must meet emergency treatment criteria and are limited to:

- Emergency room care
- Physician services
- Inpatient hospitalization not to exceed limits established for other Medicaid members
- Ambulance service to the emergency room or hospital
- Inpatient and outpatient pharmacy services related to the emergency treatment

Hospital outpatient follow-up visits or physician office visits related to the emergency care are not included in the covered services.

Client Medical Management (CMM)

The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 431.54(e-f) and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC

30-130-820. (See the “Exhibits” section at the end of this chapter for detailed information on the CMM Program.)

Providers may refer Medicaid patients suspected of inappropriately using or abusing

Medicaid services to DMAS's Recipient Monitoring Unit. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and/or pharmacy in the Client Medical Management Program.

Referrals may be made by telephone or in writing. The number for the Recipient Monitoring

Unit is (804) 786-6548 or toll-free (888) 323-0589. Referrals can also be faxed to (804) 3718891. Office hours are 8:15 a.m. – 5:00 p.m., Monday through Friday except state holidays. Voice mail receives after-hours referrals.

Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

When making a referral, provide the member's name and Medicaid number and a brief statement regarding the nature of the utilization problems. Copies of pertinent documentation, such as emergency records, would be helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Sources of Information

MediCall Automated Voice Response System

Toll-free numbers are available 24-hours-per-day, seven days a week, to confirm member

eligibility status, claim status and check status. The numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Providers access the system using their Virginia Medicaid provider number as identification. Specific instructions on the use of the verification systems are included in “Exhibits” at the end of this chapter.

Automated Response System (ARS)

Providers may use the Internet to verify member eligibility and perform other inquiry functions. Inquiries can be submitted in real-time. Specific instructions on the use of the ARS are included in “Exhibits” at the end of this chapter.

HELPLINE

A toll-free "HELPLINE" is available to assist providers in interpreting Medicaid policy and procedures and in resolving problems with individual claims. The HELPLINE numbers are:

- (804)786-6273 Richmond Area & out-of-state long distance
- 1-800-552-8627 In-state long distance (toll free)

The HELPLINE is available Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays.

The Virginia Medicaid provider number must accompany all provider inquiries (both written and via the HELPLINE). All provider information and data are filed by provider number. This number will expedite recovery of the requested information.

Do not use these HELPLINE numbers for member eligibility verification and eligibility questions. Local departments of social services are responsible for supplying information to members, and members who have questions about the Medicaid Program should be directed to their local departments of social services. If MediCall is not available, the data will also be unavailable to the HELPLINE (when the system is down).

The Medicaid HELPLINE and MediCall numbers are for provider use only and should not be given to members.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation.

The Virginia MMIS will accommodate the following Electronic Data Interchange (EDI) transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1.

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) □ 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response.

Although not mandated by HIPAA, DMAS has opted to produce an unsolicited 277 transaction to report information on pending claims.

If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

Provider Manual Updates

This manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. Accordingly, revised pages or sections will be issued by the Department of Medical Assistance Services (DMAS) as needed.

Notice of Provider Responsibility

The provider is responsible for reading and adhering to the policies and regulations explained in this manual and for ensuring that all employees do likewise. The provider also certifies by his or her personal signature or the signature of an authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Satisfaction and payment of any claim will be from federal and State funds, and any provider who submits false claims, statements, or documents may be prosecuted under applicable federal or State laws.

THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM

GENERAL INFORMATION

The Virginia Medical Assistance MediCall System offers Medicaid providers twenty-four hour-a-day, seven-day-a-week access to current member eligibility information, check status, claims status, prior authorization information, service limit information, pharmacy prescriber identification number cross reference, and information to access member eligibility and provider payment verification via the Internet. MediCall is an enhancement to the previous Medicaid Audio Verification Response System (AVRS).

Not only does MediCall offer providers flexibility in choosing the time of day for their inquiries, but it also makes efficient use of staff time. A valid provider number and a touchtone telephone are required to access MediCall.

To reach an operator while using the member eligibility verification feature of MediCall, key "0" at any prompt within the Member Eligibility menu. Operator assisted calls are limited to three name searches per call. The operator will not be able to return the caller to MediCall for further inquiries. Operators are available from 8:30 a.m. to 4:30 p.m. Eastern time, Monday through Friday except for state holidays.

MediCall prompts the caller throughout the inquiry, giving and receiving only essential,

pertinent information. The data provided is the most up-to-date information available, direct from the Medicaid eligibility, claims and remittance databases. If the caller waits too long to respond to a system prompt, the call will be disconnected.

System downtime will be scheduled during non-peak hours. If the caller dials MediCall during this time, the caller will be informed that the system is unavailable. System downtime is typically scheduled for:

2:00 a.m. to 4:00 a.m. Daily 2:00 a.m. to 6:30
a.m. Thursday

10:00 p.m. Saturday to 6:00 a.m. Sunday

The telephone numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

If you have any questions regarding the use of MediCall, contact the Medicaid Provider "HELPLINE." The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The HELPLINE numbers are:

1-804-786-6273 Richmond Area and out of state long distance

In state long distance (toll-free) 1-800-552-8627

HOW TO USE THE SYSTEM

To access MediCall, the provider must have a currently active Medicaid provider number. The provider's number is verified before access to MediCall is authorized.

Responses by the caller to MediCall are required within a specified period of time. If the time limit is exceeded, the call will be disconnected. The caller should have the following information available before calling:

- 10 digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Member Medicaid Number (12 digits) or Social Security Number (9 digits) **and**
Date of Birth (8 digits) in month, day, century and year format (mmddyyyy)
(necessary for member eligibility verification and claims status)
- From and Thru Date(s) of Service in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status). The caller will have the following limits when entering dates of service:
 - The caller does not have to enter a **Thru** date of service if services were rendered on a single day. Pressing the # key prompts the system to continue.
 - Future month information is only available in the last week of the current month.
 - Inquiries cannot be on dates of service more than one year prior to the date of inquiry.

After dialing the MediCall number, the system will ask for the NPI or API. Enter the 10 digit number and select from the following options:

- Press "1" for member eligibility verification.

- Press “2” for claims status.
- Press “3” for recent check amounts.
- Press “4” for service authorization information.
- Press “5” for service limit information.

MEMBER ELIGIBILITY VERIFICATION

Enter the From and Thru dates of service. **The service dates for member eligibility verification cannot span more than 31 days.** When the dates of service have been entered, MediCall will verify the information and respond by speaking the first six letters of the last name and the member's Medicaid number for confirmation.

Remain on the line to obtain important member information that might affect payment, such as:

- Special Indicator Codes (Copayment)
- Client Medical Management Information Including Pharmacy/Physician Telephone Number
- Medicare Eligibility
- Other Insurance Coverage

- Special Coverage (QMB, QMB--Extended)
- "MEDALLION" Participation (prior to July, 2012)
- Managed Care Organization provider name and assignment dates

At this point, MediCall will prompt the caller for the next action. The caller may ask for additional dates of service on this member, or may inquire on another member.

The caller may check up to **three** dates of service for each member and inquire on up to **three** members per call.

If the caller is using a Social Security Number instead of the member ID number, the dates of service will relate to the first member ID reported. If multiple open records exist for the same Social Security Number, you will be advised to contact the local department of social services. You will be given a 3-digit city/county code of the appropriate agency and a 5-digit caseworker code. A cross-reference list of the city/county codes is provided as an exhibit to this chapter.

The caller will receive a "not eligible" response if the future dates about which he or she inquires are beyond the information on file.

A response, "not eligible," will be given if the member is not eligible for all days within the time span entered.

PROVIDER CHECK LOG

The most recent check information is presented by invoice type. This inquiry permits the provider to receive check dates and amounts from the most recent three remittances.

CLAIMS STATUS

For claims status information, the MediCall system will prompt the provider to choose the among the following invoice types (additional information in italics).

- For inpatient care, press 01.
- For long-term care, press 02.
- For outpatient hospital, home health or rehabilitation services, press 03.
- For personal care, press 04.
- For practitioner (physician CMS-1500 billing), press 05.
- For pharmacy, press 06.
- For independent labs (outpatient lab services), press 08.
- For Medicare crossover, press 09.
- For dental, press 11.
- For transportation, press 13.

For claims status, the From date cannot be more than 365 days in the past. The Thru date cannot be more than 31 days later than the From date. After keying the member identification number and the From and Thru date(s) of service, MediCall will provide the status of each claim up to and including five claims. MediCall will prompt for any additional claims or return to the main menu.

SERVICE AUTHORIZATION INFORMATION

The From and Thru dates for prior authorization cannot span more than 365 days. When the 12-digit member ID number and the 8-digit from and through dates of service have been entered, you will be prompted to enter the 11-digit prior authorization number, if known. If you do not know the prior authorization number, then press the pound (#) key. MediCall will verify prior authorization data on file. The system will prompt you to return additional prior authorization data for the same member and dates, enter new dates for the same member, another prior authorization number for the same member or to enter another member ID number to begin a new inquiry.

SERVICE LIMITS INFORMATION

Service limits can be obtained by service type or procedure code:

- For occupational therapy, press 1. □ For physical therapy, press 2 □ For speech therapy, press 3.
- For home health aide, press 4.
- For home health skilled nursing, press 5.
- For DME purchases, press 6 and for DME rentals, press 7.

For occupational therapy, speech therapy or physical therapy the MediCall system will return non-school based and school based service limits separately.

PRESCRIBING PROVIDER ID

Only enrolled Pharmacy providers can access this choice. When prompted, the caller should enter the license number of the prescriber. MediCall will return the first six letters of the prescriber's last name and Medical Assistance provider number. If the prescriber is not

active in Virginia Medicaid, you will receive a message that the number is not on file.

The Automated Response System (ARS)

GENERAL INFORMATION

The Automated Response System (ARS) offers Medicaid and FAMIS providers twenty-four-hour-a-day, seven-day-a-week Internet access to current member eligibility information, service limits, claim status, service authorizations, and provider payment history. This weenabled tool helps provide cost-effective care for members, and allows providers to access current information quickly and conveniently.

The ARS can be accessed through the Virginia Medicaid Web portal at www.virginiamedicaid.dmas.virginia.gov. Please visit the portal for information on registration and use of the ARS.

CITY/COUNTY CODES

(The Three-Digit Numerical Identifier of the Local Social Services/Welfare Agency Currently Handling the Case)

If two or more member records using the same SSN are active on the same date of service, inquirers are prompted to contact the Social Services agency for resolution.

COUNTIES

001 Accomack	049 Cumberland	097 King and Queen
003 Albermarle	051 Dickenson	099 King George
005 Alleghany	053 Dinwiddie	101 King William
007 Amelia	057 Essex	103 Lancaster
009 Amherst	059 Fairfax	105 Lee
011 Appomattox	061 Fauquier	107 Loudoun
013 Arlington	063 Floyd	109 Louisa
015 Augusta	065 Fluvanna	111 Lunenburg
017 Bath	067 Franklin	113 Madison
019 Bedford	069 Frederick	115 Mathews
021 Bland	071 Giles	117 Mecklenburg

023	Botetourt	073	Gloucester	119	Middlesex
025	Brunswick	075	Goochland	121	Montgomery
027	Buchanan	077	Grayson	125	Nelson
029	Buckingham	079	Greene	127	New Kent
031	Campbell	081	Greensville	131	Northampton
033	Caroline	083	Halifax	135	Nottoway
035	Carroll	085	Hanover	137	Orange
037	Charlotte	087	Henrico	139	Page
041	Chesterfield	089	Henry	141	Patrick
043	Clarke	091	Highland	143	Pittsylvania
045	Craig	093	Isle of Wight	145	Powhatan
047	Culpeper	095	James City	147	Prince Edward
149	Prince George	167	Russell	179	Stafford
153	Prince William	169	Scott	181	Surry
155	Pulaski	171	Shenandoah	183	Sussex
157	Rappahannock	173	Smyth	185	Tazewell
159	Richmond	175	Southampton	187	Warren
161	Roanoke	177	Spotsylvania	191	Washington
193	Westmoreland	195	Wise	197	Wythe
199	York				

CITIES

510	Alexandria	620	Franklin	710	Norfolk
515	Bedford	630	Fredericksburg	720	Norton
520	Bristol	640	Galax	730	Petersburg
530	Buena Vista	650	Hampton	735	Poquoson
540	Charlottesville	660	Harrisonburg	740	Portsmouth
550	Chesapeake	670	Hopewell	750	Radford
570	Colonial Heights	678	Lexington	760	Richmond
580	Covington	680	Lynchburg	770	Roanoke
590	Danville	683	Manassas	775	Salem
595	Emporia	685	Manassas Park	780	South Boston
600	Fairfax	690	Martinsville	790	Staunton
610	Falls Church	700	Newport News	800	Suffolk
810	Virginia Beach	820	Waynesboro	830	Williamsburg
840	Winchester				

976 Central
Processing
Unit for
FAMIS

STATE MENTAL HEALTH FACILITIES

- 983 Southern Virginia Mental Health Institute
985. Southeastern State Hospital
986. Northern Virginia Training Center
987. Virginia Treatment Center
988. Northern Virginia Mental Health Institute
990. Central Virginia Training Center
991. Western State Hospital
992. Southwestern State Hospital
993. Piedmont State Hospital
994. Eastern State Hospital
996. Hiram Davis Hospital
997. Catawba State Hospital

CLIENT MEDICAL MANAGEMENT INTRODUCTION

The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 456.3 and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC 30130-810.

MEMBER RESTRICTION

Utilization Review and Case Management

Federal regulations allow states to restrict members to designated providers when the members have utilized services at a frequency or amount that is not medically necessary.

Restricted members are identified and managed by the Recipient Monitoring Unit (RMU) in the Division of Program Integrity.

CMM enrollment is based upon review of the individual member's utilization patterns. All Medicaid members except MCO members and institutionalized long-term care residents are eligible for utilization review by RMU staff. If the member's utilization patterns meet the criteria for enrollment in CMM, the member is notified to select designated primary providers. Examples of inappropriate utilization are:

- Emergency room use for medical problems that could be treated in a physician's office;
- Using more than one physician and/or pharmacy to receive the same or similar medical treatment or prescriptions; and
- A pattern of non-compliance which is inconsistent with sound fiscal or medical practices.

Each CMM member is assigned a case manager in the Recipient Monitoring Unit to assist both members and providers with problems and questions related to CMM. The case manager is available to:

- Resolve case problems related to CMM procedures and provider assignments;
- Counsel the member on the appropriate access to healthcare;
- Approve/deny requests for provider changes; and
- Complete a utilization review prior to the end of the enrollment period to determine if CMM restriction should be extended.

□

Member Enrollment Procedures

Members identified for CMM enrollment receive a letter explaining the member/provider relationships under medical management. The letter includes the Member/Primary Provider Agreement forms (see the sample forms at the end of this section) with directions for completing and returning the form to the Recipient Monitoring Unit. Members are given thirty (30) days to select their primary providers by obtaining their signatures on the form.

The provider's signature indicates agreement to participate as the CMM provider for the member. DMAS reviews member requests for specific providers for appropriateness and to ensure member accessibility to all required medical services.

Members also have thirty (30) days from the receipt of the restriction notice to appeal enrollment in CMM. Assignment to designated providers is not implemented during the appeal process.

CMM enrollment is for 24 months. Assignment to both a physician and pharmacy is made with few exceptions.

When members do not return choices to the Recipient Monitoring Unit or have difficulty in finding providers, RMU staff will select providers for them. RMU staff contact providers directly to request participation as a CMM provider for the member and follow-up by mailing or faxing the agreement form for the provider's signature.

When completed agreement forms are received, the member is enrolled in CMM effective the first of the next month in which a restricted Medicaid card can be generated. Both members and selected providers are notified by mail of the enrollment date.

Members enrolled in the Client Medical Management can be identified through the process of eligibility verification. A swipe of the Medicaid ID card will return the names and telephone numbers of the primary care physician and designated pharmacy. The dates of assignment to each provider are also included. This information is also available through the MediCall System and the web-based Automated Response System (ARS). Instructions for both resources are provided in this chapter.

Each CMM member also receives an individual Medicaid coverage letter with the name(s) and address of the designated primary health care provider and/or designated pharmacy printed on the front each time there is a change in providers.

Designated Primary Care Physicians (PCP)

Any physician enrolled in Medicaid as an individual practitioner may serve as a designated primary care physician (PCP) except when:

- The physician's practice is limited to the delivery of emergency room services; or
- The physician has been notified by DMAS that he or she may not serve as a designated provider, covering provider, or referral provider for restricted members.

Federally Qualified Community Health Centers (FQHCs) and Rural Health Clinics (RHCs) may serve as PCPs also. Other provider types such as ambulatory care centers may be established as designated providers as needed but only with the approval of DMAS.

Primary care physicians are responsible for coordinating routine medical care and making referrals to specialists as necessary. The PCP must arrange 24-hour coverage when they are not available and explain to their assigned members all procedures to follow when the office is closed or when there is an urgent or emergency situation.

The provider's *NPI number* is used for billing and referral purposes.

Designated Pharmacies

Any pharmacy enrolled as a community pharmacy billing on the Pharmacy Claim Form or other acceptable media may serve as a designated pharmacy unless the pharmacy has been notified by DMAS that it may not serve as a designated provider.

Designated pharmacies must monitor the member's drug regimen. The pharmacist should fill prescriptions from the PCP, referred physicians, and emergency prescriptions. Referrals can be confirmed by reviewing the member's copy of the referral form or by contacting the

PCP's office. Close coordination between the PCP and the pharmacist, particularly if a medication problem has been identified, is a very important component of the program.

Changing Designated CMM Providers

The member or designated provider may initiate a request for a change of a designated provider by contacting the Recipient Monitoring Unit. Designated providers requesting a change must notify the member in addition to contacting RMU. If the designated provider requests the change and the member does not select a new provider by the established deadline, RMU shall select for them.

All changes must be preauthorized by DMAS RMU staff. The member's RMU case manager may contact the provider before making a final decision on the change request to try to resolve questions or issues and avoid unnecessary changes. If DMAS denies a member's request, the member shall be notified in writing and given the right to appeal the decision. Changes are allowed for:

1. Relocation of the member or provider;
2. Inability of the designated provider to meet the routine medical/pharmaceutical needs of the member; or
3. Breakdown of the relationship between the provider and member.

Provider changes can occur any time of the month because the effective date is the date the new provider signs the Member/Primary Provider Agreement form. When a new provider is assigned, RMU mails a letter to the member confirming the effective date of the change. The letter instructs the member *to show the letter with the Medicaid identification card*. Letters go to the affected providers also. All verification inquiries will return the new primary provider from the date it is entered into the computer system.

A PCP No Longer in Practice

If a provider leaves the practice or retires, he or she must notify CMM so that the restricted member can be reassigned to a new PCP.

Covered Services and Limitations

Under CMM, DMAS will pay for covered outpatient medical and/or pharmaceutical services only when they are provided (1) by the designated providers, (2) by physicians seen on written referral from the PCP, (3) by covering providers linked with the designated provider in a CMM Affiliation Group, or (4) in a medical emergency. A medical emergency means that a delay in obtaining treatment may cause death or serious impairment of the health of the member. Payment for covered outpatient services will be denied in all other instances (unless the covered services are excluded from Client Medical Management Program requirements), and the member may be billed for the services.

All services should be coordinated with the designated provider. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

Physician Services

A Medicaid-enrolled physician who is not the PCP may provide and be paid for outpatient services to these members only:

- In a medical emergency situation in which a delay in the treatment may cause death or result in lasting injury or harm to the member.
- On written referral from the PCP using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians who have not been affiliated with the PCP.

- When they are a part of a CMM provider affiliation group that includes the PCP.
- For other services covered by DMAS which are excluded from the Client Medical Management Program requirements.

Services Excluded from PCP Referral

These services should be coordinated with the primary health care provider whose name appears on the member's eligibility card, but they are excluded from special billing instructions for the Client Medical Management Program.

Covered services that do not need a referral include:

- Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) wellchild exams and screenings (members under age 21);
- Immunizations (member under age 21);
- Family planning services;
- Expanded prenatal services, including prenatal group education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants;
- Dental services (members under age 21);

- Services provided under Home and Community-Based Care Waivered Services;
- Hospice services;
- Renal dialysis services;
- Routine vision care services (routine diagnostic exams for members of all ages and eyeglasses for members under age 21). Medical treatment for diseases of the eye and its appendages still requires a written referral;
- Audiology services;
- Podiatry services;
- Prosthetic services;
- MH/ID community rehabilitative services;
- Psychiatric diagnostic and therapeutic services (limited sessions of outpatient treatment);
- Inpatient hospital services;
- Life-threatening medical emergencies; and

- School-based services.

CMM Provider Affiliation Groups

Physician affiliation groups allow covering physicians to see each other's patients without a written referral. CMM affiliations may be set up for physicians within a practice or for the single practitioner who arranges coverage by a physician not sharing office space. Affiliations can be open-ended or for a specified period of time (such as when the PCP is away from the office for days or weeks). CMM affiliations may include physicians, Rural Health Clinics, Federally Qualified Health Clinics (FQHC), and nurse practitioners.

Affiliations are not member-specific. This means that once provider numbers are affiliated, claims will pay for all CMM members who receive services from a member of an affiliation group that includes the member's PCP on the date of service.

The PCP requests affiliation by completing the CMM Provider Affiliation Form (see sample form at the end of this section) and returning it to the Recipient Monitoring Unit (RMU). The form is used to set up a new affiliation group or to update a group. Providers are responsible for notifying DMAS when a new provider joins the group or a provider leaves the group to ensure claims are processed correctly. Contact the Recipient Monitoring Unit at (804) 786-6548 in Richmond, or toll-free at 1-888-323-0589, to request a form.

Emergency Room Services

Outpatient hospital emergency room services for restricted members are limited to reimbursement for medical emergencies. Emergency hospital services means that the threat to the life or health of the member necessitates the use of the most accessible hospital facility available that is equipped to furnish the services. Reimbursement may be conditional upon the review of the emergency-related diagnosis or trauma ICD diagnosis codes and the necessary documentation supporting the need for emergency services. Additional guidelines for payment of medical services provided in the outpatient hospital emergency room setting are listed in Chapter IV "Covered Services" in this manual.

CMM clients must have a written PCP referral in order for non-emergency services provided in the emergency room to be reimbursed at an all-inclusive rate. The PCP must use the Practitioner Referral Form, DMAS-70. Payment will be denied without a referral unless there is a life-threatening emergency. Non-emergency services provided without a PCP referral become non-covered services, and the member is responsible for the full cost of the emergency room visit.

CMM also requires a PCP referral form for:

- Reimbursement to CONSULTING physicians who treat a CMM client in the emergency room setting, and
- Reimbursement for any follow-up outpatient or office consultations resulting from an ER visit.

Emergency Pharmacy Services

Prescriptions may be filled by a non-designated pharmacy only in emergency situations (e.g., insulin or cardiac medications) when the designated pharmacy is closed or the designated pharmacy does not stock or is unable to obtain the drug.

Provider Reimbursement and Billing Instructions

Management Fees

Each physician, FQHC, or Rural Health Clinic that serves as a CMM primary care provider (PCP) receives a monthly case management fee of \$5.00 for each assigned CMM member. Payment is made through a monthly remittance process. PCPs receive a monthly report listing the CMM members assigned the previous month for whom payment is made.

PCP and Designated Pharmacy Providers

DMAS pays for services rendered to CMM members through the existing fee-for-service methodology. Designated providers (PCP's and pharmacies) bill Medicaid in the usual manner, but non-designated providers who are not affiliated with the CMM provider must follow special billing instructions. Complete instructions for the CMS 1500 (08-05) and UB-04 billing invoices as well as Point-of-Sale (POS) billing can be found in the billing instruction chapter of this manual.

Affiliated Providers

Providers who are affiliated with a designated CMM provider in the Medicaid system bill Medicaid in the usual manner with no special billing instructions. Claims process with a look-up to the CMM Affiliation Groups in the system.

Referral Providers

To receive payment for their services, referral providers authorized by the client's PCP to provide treatment to that client must place the Provider Identification Number of the PCP in Locator 17a (1D qualifier followed by the API number) or 17b (National Provider Identifier number of referring physician - 17B requirement effective 5/23/08) of the CMS-1500 (0805) and attach the Practitioner Referral Form.

Physicians Billing Emergency Room Services

When billing for emergency room services on the CMS-1500, the attending physician bills evaluation and management services with CPT codes 99281-99285 and enters "Y" in Block 24-C. When the PCP has referred the client to the emergency room, place the PCP's NPI number in Block 17b on the CMS -1500 and attach the Practitioner Referral form.

Facilities Billing Emergency Room Services with a Referral

When billing for emergency room services on the on the UB-04 CMS 14-50, place the PCP's provider number in space 78, and attach the Practitioner Referral Form.

Non-designated Pharmacy Providers

When billing on the Pharmacy Claim Form or as a Point-Of-Sale (POS) provider, enter code "03" in the "Level of Service" field to indicate emergency.

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See "Exhibits" at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate members on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voice mail receives after-hours referrals. Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the member and a brief statement about the nature of the utilization problems. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

PROVIDER RESTRICTION

Restricted providers are identified and managed by the DMAS Provider Review Unit. States may restrict providers from participation in the Medicaid Program when the provider has provided items or services at a frequency or amount not medically necessary or has provided items or services of a quality that does not meet professionally recognized standards of health care. State regulations allow DMAS to restrict providers' participation as designated providers, referral providers, or covering providers for CMM restricted members when a provider has billed services at a frequency or level exceeding that which is medically necessary or when a provider's license to practice has been revoked or suspended in Virginia by the appropriate licensing board.

Provider restriction is for 24 months. Providers may appeal any proposed restriction in accordance with the *Code of Virginia*, Section 2.2-4000 et seq., as discussed in the chapter containing utilization review and control information in this manual. Restriction is not implemented pending the result of a timely appeal request.

Provider Participation Requirements (Lab)

A participating provider is an independent laboratory that has a current signed participation agreement with the Department of Medical Assistance Services, is licensed and certified by the appropriate licensing agency, and meets Medicare-Medicaid participation requirements.

Provider Enrollment (Lab)

Any provider of services must be enrolled and have a current participation agreement with the Virginia Medicaid Program prior to billing for any services provided to Medicaid recipients. (See the “Exhibits Section” at the end of this chapter for a sample provider agreement.) Continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of the provider license. Failure to renew the license through the licensing authority shall result in the termination of the Medicaid Participation Agreement. All participants are required to complete new agreement forms when a change of ownership occurs.

Upon receipt of the above information, the ten-digit National Provider Identifier (NPI) number that was provided with the enrollment application is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.

DMAS is informing the provider community that NPIs may be disclosed to other Healthcare Entities pursuant to CMS guidance. The NPI Final Rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs for use of the NPIs in HIPAA standard transactions. DMAS may share your NPI with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to Referring Provider NPIs and Prescribing Provider NPIs.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Please read the entire manual before billing Medicaid. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

Requests for Enrollment

All providers who wish to participate with Virginia Medicaid are being directed to complete their request via the online enrollment through our Virginia Medicaid web-portal. If a provider is unable to enroll electronically through the web, they can download a paper application from the Virginia Medicaid web-portal and follow the instructions for submission. Please go to www.virginiamedicaid.dmas.virginia.gov to access the online enrollment system or to download a paper application.

DMAS strongly encourages providers to enroll or make updates electronically via our web portal. An application for participation submitted on paper will add additional time to the processing of your enrollment and to your request to update your provider file.

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only accept the provider enrollment applications that have the provider screening questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov.

If you have any questions regarding the online or paper enrollment process, please contact the Provider Enrollment Services at toll free 1-888-829-5373 or local 1-804-270-5105.

Provider Screening Requirements

All providers must now undergo a federally mandated comprehensive screening before their application for participation is approved by DMAS. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every 5 years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as “limited”, “moderate” or “high”. Please refer to the table at the end of this chapter for a complete mapping of the provider risk categories and application fee requirements by provider class type.

Limited Risk Screening Requirements

The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and finger prints. All other screening requirements excluding criminal background checks and finger prints are required at this time.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers are required to pay an application fee. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online

enrollment tool, and revalidation process. **The application fee requirements are also outlined in Appendix section of this provider manual.**

The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied.

An appeal of a hardship exception determination must be made to CMS as described in 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected.

Revalidation Requirements

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via our web portal.

Registration into the Virginia Medicaid Web Portal will be required to access and use the online enrollment and revalidation system.

All enrolled providers in the Virginia Medicaid program will be notified in writing of a revalidation date and informed of the new provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, DMAS may rely on the enrollment and screening facilitated by CMS to satisfy our provider screening requirements.

Ordering, Referring, and Prescribing (ORP) Providers

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or

services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members they must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

Please go to Chapter V of this provider manual to review the new billing procedures related to the implementation of these new screening requirements.

Participation Requirements (Lab)

Providers approved for participation in the Virginia Medicaid Program must perform the following activities as well as any other specified by DMAS:

- Immediately notify the Department of Medical Assistance Services, in writing, of any change in the information which the provider previously submitted to the Department.
- Ensure freedom of choice to recipients seeking medical care from any other provider qualified to perform the needed service(s) and participating in the Medicaid Program at the time the service was performed.
- Assure the recipient's freedom to reject medical care and treatment.
- Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, religion, or national origin.
- Provide services and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973 requiring that all necessary accommodations be made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities, and disabilities of coordination (refer to section regarding the Rehabilitation Act on page five of this chapter).
- Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.
- Charge the Department of Medical Assistance Services for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.
- Accept as payment in full the amount reimbursed by the Department of Medical Assistance Services. The Code of Federal Regulations, 42 CFR, Section 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the State providing the recipient was Medicaid eligible at the time service was rendered. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid

allowance for the service rendered. For example: If a third party payer reimburses \$5.00 out of an \$8.00 charge, and Medicaid's allowance is \$5.00, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the \$3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative.

- Accept assignment of Medicare benefits for eligible Medicaid recipients.
- Use Program-designated billing forms for submission of charges.
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided.

Such records must be retained for a period of five years from the date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to section regarding documentation of records on page four of this chapter.)

- Furnish to authorized State and federal personnel, in the form and manner requested, access to records and facilities.
- Disclose, as requested by the Department of Medical Assistance Services, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance.
- Hold information regarding recipients confidential. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. The state agency shall not disclose individual recipient medical information to the public.

Provider Responsibilities to Identify Excluded Individuals and Entities

In order to comply with Federal Regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.
2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.

3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS**Attn: Program Integrity/Exclusions**

600 E. Broad St, Ste 1300

Richmond, VA 23219

E-mailed to: providerexclusions@dmass.virginia.gov**Participation Conditions (Lab)**

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements.

Certification and Recertification

The Virginia Medicaid Program is dependent upon the participation and cooperation of physicians who provide or order health care services. The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with excellence in medical practice and economic considerations.

Physicians, General

Medicaid recognizes the physician as the key figure in determining utilization of health services. The physician decides upon admission to a hospital; orders tests, drugs, and treatments; and determines the length of stay. The Program calls for substantiation of certain physician decisions as an element of proper administration and fiscal control. Payment for certain covered services may be made to a provider of services only if there is a physician's certification concerning the necessity of the services furnished, and, in certain instances, only if there is a physician's recertification to the continued need for the covered services.

Medicaid Program Information (Lab)

A provider having access to DMAS publications as part of a group practice may not wish to receive a provider manual and Medicaid Memos. To suppress the receipt of provider manuals and Medicaid Memos, complete the Program Information form (see the copy in the "Exhibits Section" at the end of this chapter.) and return it to:

Virginia Medicaid -PES



Independent Laboratory

PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax - 804-270-7027

Upon receipt, Xerox - PES will process the completed form and the provider named on the form will no longer receive publications from Virginia Medicaid. To resume the mailings, the provider must submit a written request sent to the same address.

Requirements of the Section 504 of the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each provider enrolled in the Virginia Medical Assistance Program has the responsibility for making provisions for individuals with disabilities in the provider's programs or activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. By signing the check, the provider indicates compliance with Section 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

Documentation of Records (Lab)

All laboratory tests billed to the Program must have documented results. Those laboratory tests listed as quantitative tests by the CPT must be documented by a numerical result. Qualitative tests are to be documented by positive or negative. Those laboratory services requiring descriptive results are to be fully documented.

Documentation examples are listed below:

Quantitative tests:

- WBC - 7,000/mm³
- Glucose - 85 mg/100ml

Qualitative tests:

- Monoscreen - positive
- Pregnancy test - negative

Descriptive tests:

- Urine microscopic - clear, yellow-brown, few wbc, rare renal epithelial cell
- Urine culture - greater than 105/ml E. coli

The record must identify the patient on each page.

Termination of Provider Participation (Lab)

The participation agreement is not time-limited, and will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no billing within 36 months), or resignation by the provider. DMAS will request a copy of the renewed licensure/certification prior to its expiration.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and Xerox - PES 30 days prior to the effective date. The addresses are:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Virginia Medicaid -PES
PO Box 26803
Richmond, Virginia 23261-6803

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

The Code of Virginia, Chapter 10, Department of Medical Assistance Services, Section 32.1- 325(c), mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

Appeals of Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325D and E. The provider may appeal the decision in accordance with the Administrative Process Act (Virginia Code §2.2-4000 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division within 15 calendar days of the receipt of the notice of termination or denial.

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

- 1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or
- 2) The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

Adverse Action – means the termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

- 1) A member appeal is:
 - a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R. §§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or
 - b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS

may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R. §§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

- 2) For services that have already been rendered, a provider appeal is:
 - a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq.* and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq.*; or
 - b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq.* and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq.*

Internal Appeal – means a request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Reconsideration – means a provider's request for review of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for member appeals. Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Transmit – means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

MEMBER APPEALS

Information for providers seeking to represent a member in the member's appeal of an adverse benefit determination is located in Chapter III.

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division
Department of Medical Assistance Services
600 East Broad Street,
Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

For services that have been rendered and applicable reconsideration or MCO internal appeal rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et. seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et. seq.*

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will

result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System (“AIMS”) at <https://www.dmas.virginia.gov/appeals/>. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at <https://www.dmas.virginia.gov/appeals/>. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
 - o Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
 - o Email to appeals@dmas.virginia.gov; or
 - o Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider’s receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et. seq.* and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

Client Appeals (GAP)

The Code of Federal Regulations at 42 CFR §431, Subpart E, the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370, and 12VAC-30-135-487 through 12VAC30-135-495 require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid client or by an authorized representative on behalf of the client. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within

required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the client may be expected to repay DMAS for all services received during the appeal period. For this reason, the client may choose not to receive continued services. The entity that took action (Cover Virginia or the service authorization contractor) will be notified by DMAS to reinstate services if continuation of services is applicable. If services are continued or reinstated due to an appeal, they must continue until a decision is rendered by the hearing officer.

Appeals must be requested in writing and postmarked or submitted within 30 days of receipt of the notice of adverse action. The client or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

The appeal request must be signed and mailed to the:

Appeals Division

Department of Medical Assistance
Services

600 E. Broad Street

Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 452-5454

The Appeals Division will notify clients of the date, time and location of the appeal hearing if the appeal is valid and a hearing is granted. The hearing will be conducted by a DMAS hearing officer. Most hearings will be done by telephone.

The hearing officer's decision is the final administrative decision by DMAS. If the client does not agree with the hearing officer's decision, he/she may appeal it directly to the Circuit Court in the city or county of residence.

Provider Risk Category Table

Application	Rule Risk Category	App Fee Requirement Yes(Y) or No(N)
Comprehensive Outpatient Rehab Facility (CORF)	Moderate	Y
Hospital	Limited	Y
Hospital Medical Surgery Mental Health and Mental Retarded	Limited	Y
Hospital Medical Surgery Mental Retarded	Limited	Y
Hospital TB	Limited	Y
Long Stay Hospital	Limited	Y
Long Stay Inpatient Hospital	Limited	Y
Private Mental Hospital(inpatient psych)	Limited	Y
Rehab Outpatient	Limited	Y
Rehabilitation Hospital	Limited	Y
Rehabilitation Hospital	Limited	Y
State Mental Hospital(Aged)	Limited	Y
State Mental Hospital(less than age 21)	Limited	Y
State Mental Hospital(Med-Surg)	Limited	Y
Audiologist	Limited	N
Baby Care	Limited	N
Certified Professional Midwife	Limited	N
Chiropractor	Limited	N
Clinical Nurse Specialist - Psychiatric Only	Limited	N
Clinical Psychologist	Limited	N
Licensed Clinical Social Worker	Limited	N
Licensed Marriage and Family Therapist	Limited	N
Licensed Professional Counselor	Limited	N
Licensed School Psychologist	Limited	N
Nurse Practitioner	Limited	N
Optician	Limited	N
Optometrist	Limited	N
Physician	Limited	N
Physician	Limited	N
Physician	Limited	N
Podiatrist	Limited	N
Psychiatrist	Limited	N
Psychiatrist	Limited	N
Substance Abuse Practitioner	Limited	N
Ambulance	Moderate	Y
Ambulance	Moderate	Y
Durable Medical Equipment (DME)	Moderate -Revalidating High - Newly enrolling	Y
Emergency Air Ambulance	Moderate	Y
Emergency Air Ambulance	Moderate	Y
Hearing Aid	Limited	N
Home Health Agency - State Owned	Moderate -Revalidating High - Newly enrolling	Y

Home Health Agency - Private Owned	Moderate -Revalidating High - Newly enrolling	Y
Hospice	Moderate	Y
Independent Laboratory	Moderate	Y
Local Education Agency	Limited	N
Pharmacy	Limited	N
Prosthetic Services	Moderate -Revalidating High - Newly enrolling	Y
Renal Unit	Limited	Y
Adult Day Health Care	Limited	N
Private Duty Nursing	Limited	N
Federally Qualified Health Center	Limited	Y
Health Department Clinic	Limited	N
Rural Health Clinic	Limited	Y
Developmental Disability Waiver	Limited	N
Alzheimer's Assisted Living Waiver	Limited	N
Treatment Foster Care Program	Limited	N
Qualified Medicare Beneficiary (QMB)	Limited	N
ICF-Mental Health	Limited	Y
ICF-MR Community Owned	Limited	Y
ICF-MR State Owned	Limited	Y
Intensive Care Facility	Limited	Y
Skilled Nursing Home	Limited	Y
SNF-Mental Health	Limited	Y
SNF-MR	Limited	Y
Psych Residential Inpatient Facility	Limited	Y
Consumer Directed Service Coordination	Limited	N
Personal Care	Limited	N
Respite Care	Limited	N
Personal Emergency Response System	Moderate -Revalidating High - Newly enrolling	Y
Case Management DD Waiver	Limited	N
CMHP Transition Coordinator	Limited	N
Transition Coordinator	Limited	N
PACE	Limited	N
Family Caregiver Training	Limited	N
Mental Retardation Waiver	Limited	N
Mental Health Services	Limited - all others Moderate -- Community Mental Health Centers	Y - only for Mental Health Clinics
Early Intervention	Limited	N
Group Enrollment	Limited	N
Group Enrollment	Limited	N
Ambulatory Surgical Center	Limited	Y
Ordering, Referring, or Prescribing Provider	Limited	N

Member Eligibility

Determining Eligibility

The Department of Medical Assistance Services (DMAS) administers Virginia's medical assistance programs: Medicaid (called FAMIS Plus for children), FAMIS for children under age 19 years, and FAMIS MOMS for pregnant women. FAMIS and FAMIS MOMS offer coverage similar to Medicaid but have higher income thresholds. Per state regulations, eligibility determinations for the medical assistance programs are made by the local departments of social services (LDSS) and by the Cover Virginia Central Processing Unit (CPU).

Inquiries from persons who wish to apply for medical assistance should be referred to the LDSS in the locality in which the applicant resides, to the Cover Virginia Call Center at 1-855-242-8282, or the Cover Virginia website at www.CoverVA.org. DMAS will not pay providers for services, supplies, or equipment until the applicant's eligibility has been determined. (See "Assistance to Patients Possibly Eligible for Benefits.") Once an applicant has been found eligible, coverage for Medicaid can be retroactive for up to three months before the month in which the application was filed. A member's eligibility must be reviewed when a change in the member's circumstances occurs, and all members are subject to an annual renewal (redetermination) of eligibility.

Groups Covered by Medical Assistance

Individuals who apply for Medicaid are evaluated under the covered group or groups they meet. Each covered group has a prescribed income limit, and some covered groups also have an asset or resource limit. . Individuals may be eligible for full medical assistance coverage, including the payment of Medicare premiums for Medicaid members with Medicare, if they fall into one of the following covered groups and meet the nonfinancial and financial requirements for the group:

- Auxiliary Grants (AG) recipients
- Aged, blind or disabled (ABD) recipients of Supplemental Security Income (SSI) and certain former SSI recipients with "protected" status
- ABD individuals with income less than or equal to 80% of the Federal Poverty Level (FPL) who are age 65 or older and/or who are eligible for or enrolled in Medicare.
- Low-Income Families with Children (parents with a dependent child under age 18 years in the home)
- Pregnant women, and postpartum women through the end of the 60-day postpartum period (Medicaid, FAMIS MOMS)
- Newborns up to age one year born to mothers who were eligible for Medicaid or covered by FAMIS or FAMIS MOMS at the time of the birth
- Children in foster care or subsidized adoptions, and individuals under age 26 who were formerly in foster care until their discharge from foster care at age 18 or older.
- Children under age 19 years (FAMIS Plus, FAMIS)
- Adults between the ages of 19 and 64 who are not eligible for or enrolled in Medicare. These individuals are referred to as Modified Adjusted Gross Income (MAGI) Adults.
- Individuals under age 21 in institutional care
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)—women and men who

were certified through the Breast and Cervical Cancer Early Detection Program.

- Individuals who are in long-term care institutions or receiving services under a home and community-based care waiver, or who have elected hospice care

The following individuals may be eligible for limited Medicaid coverage if they meet the nonfinancial and financial requirements for their covered group:

- Qualified Medicare Beneficiaries (QMBs) with income over 80% of the FPL but within 100% of the FPL. This group is eligible for **Medicaid coverage of Medicare premiums, deductibles, and coinsurance only**.
- Special Low-Income Medicare Beneficiaries (SLMB) with income less than 120% of the FPL. This group is eligible for Medicaid coverage of **Medicare Part B premiums only**.
- Qualified Individuals (QI) with income equal to or greater than 120% but less than 135% of the FPL. This group is eligible for Medicaid coverage of the **Medicare Part B premiums only**.
- Qualified Disabled and Working Individuals (QDWI) with income up to 200% of the FPL. This group is eligible for Medicaid payment of **Medicare Part A premiums only**.
- Plan First – any individual with income equal to or less than 200% of FPL. This group is eligible for limited Medicaid coverage of family planning services only and not covered for full Medicaid benefits. If a member does not wish to be enrolled in Plan First, he or she should contact the local DSS to be disenrolled.

Medically Needy Covered Groups and Spenddown

Through a process known as “spenddown,” Medicaid provides a limited period of full coverage for certain groups of “Medically Needy” individuals who meet all of the Medicaid eligibility requirements but have excess income for full benefit Medicaid. Individuals to which spenddown may apply include:

- ABD individuals
- Pregnant women and their newborn children
- Children under age 18
- Individuals under Age 21 in institutional care, under supervision of the Department of Juvenile Justice, foster care, or subsidized adoptions
- Individuals in long-term care institutions and those receiving services under a home and community-based care waiver or who have elected hospice care.

To be eligible for Medicaid, the individual must have incurred medical expenses that at least equal the spenddown liability. If the individual’s allowable medical expenses equal the spenddown liability amount before the end of a budget period (six-month period for noninstitutionalized individuals or a one month period for institutionalized individuals), the applicant may receive a limited period of Medicaid coverage which will stop at the end of the budget period. The spenddown liability is the difference between the individual’s income and the Medically Needy income limit for the individual’s locality, multiplied by the number of months in the individual’s spenddown period. Eligibility must be re-determined in order to establish eligibility in subsequent budget periods.

An individual placed on a spenddown does **not** have full Medicaid coverage until the spenddown is met, however they may be eligible for limited Medicaid coverage, Plan First, during the spenddown

period. Medicaid cannot pay medical expenses incurred prior to the date the spenddown is met.

Emergency Medicaid Services for Aliens

To be eligible for full Medicaid benefits, FAMIS or FAMIS MOMS, an individual must be a resident of Virginia and a U.S. citizen or an alien qualified for full benefits. Individuals who do not qualify for full Medicaid benefits due to their alien status may be eligible for Medicaid coverage of emergency services if they meet all other nonfinancial and financial eligibility requirements for full Medicaid coverage.. The FAMIS and FAMIS MOMS programs do not cover emergency services for undocumented immigrants.

LDSS staff determine eligibility for receipt of emergency Medicaid coverage based on regular eligibility criteria and documentation from the provider of services that emergency services were provided. The provider may refer the individual to the LDSS or Cover Virginia (see Chapter I for information on the covered services and the coverage criteria.) For the purposes of this section, labor and delivery are considered emergency services.

Receipt of the emergency treatment will be verified by the LDSS through the member's medical record obtained from the provider. The LDSS will send a written request to the provider for the necessary documentation of the emergency service. This documentation must include all required Medicaid forms and a copy of the member's complete medical record. For inpatient hospital stays, this documentation will be the medical record for the entire hospitalization up to the 21-day limit for those over age 20.

The LDSS is authorized to approve labor and delivery services of up to three days for a vaginal delivery and five days for a cesarean section. All other services will be referred to DMAS for approval of the coverage of treatment and for establishment of the time for which this coverage will be valid.

If the member is found eligible and the emergency coverage is approved by DMAS, each provider rendering emergency care will be notified via the Emergency Medical Certification Form (#032-03-628) of the member's temporary eligibility number for coverage of the treatment of the conditions during the time stated on this form. This form will also be used to notify providers if an alien is not eligible for emergency care (See "Exhibits" at the end of this chapter for a sample of this form.).

Medicaid Eligibility for Institutionalized Individuals

An institutionalized individual is defined as one who is receiving long-term services and supports (LTSS) as an inpatient in a medical institution or nursing facility or in the home or community setting. Home and community based services (HCBS) include waiver services such as personal care, adult day health care, respite care, and the Program for All Inclusive Care for the Elderly (PACE).

To be approved for Medicaid-covered LTSS, the individual must be institutionalized in a nursing or other medical facility or have been screened and approved for HCBS. and be eligible for Medicaid in a full-benefit covered group.

If an individual is not eligible for Medicaid in any other full-benefit covered group, the individual's

eligibility in the one of the special income covered groups is determined. The policy for these groups allows a different method of determining income and resource eligibility, a higher income limit of 300% of the SSI payment for one person., An married institutionalized individual's spouse at home is referred to as the community spouse. The community spouse is able to retain a specified amount of resources in order to continue to meet maintenance needs in the community. Some of the institutionalized spouse's monthly income may also be allocated to the community spouse if certain criteria are met. At the time of application for Medicaid, the LDSS completes the resource assessment document, which produces a compilation of a couple's combined countable resources at the time one spouse became institutionalized and a calculation of a spousal share (the amount of shared resources that can be allocated to the community spouse). An institutionalized spouse with a community spouse may also request a resource assessment without submitting a Medicaid application to assist with financial planning.

Most individuals receiving LTSS have an obligation toward the cost of their care, known as the patient pay. MAGI adults do not have a patient pay responsibility.

Family Access to Medical Insurance Security (FAMIS) Plan

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Virginia's Title XXI program is known as FAMIS and is a comprehensive health insurance program for Virginia's children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit and under 200 percent of the Federal Poverty Level. FAMIS is administered by DMAS and is funded by the state and federal government.

FAMIS Covered Services

FAMIS covered services are somewhat different from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are not eligible for EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO). Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;

☐ Assistive technology

☐ Blood lead testing

- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:

☐ Intensive in-home services

☐ Therapeutic day treatment

- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations
- Disposable medical supplies
- Early Intervention services including targeted case management
- Emergency hospital services
- Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives
- Gender dysphoria treatment services
- Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)
- Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
- Inpatient substance abuse treatment services, with the following exceptions: services furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services
- Inpatient services (365 days per confinement; includes ancillary services)
- Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services
- Maternity services including routine prenatal care
- Medical formula, enteral/medical foods (sole source, specialized formula - not routine infant formula)
- Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are

covered with limitations

- Organ transplantation
- Outpatient mental health services, other than services furnished in a state-operated mental hospital
- Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, case management, and peer support services
- Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician's office or outpatient hospital department
- Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);
- Prescription drugs (mandatory generic program) and over-the-counter (optional for managed care)
- Peer support services
- Physician services, including services while admitted in the hospital, or in a physician's office, or outpatient hospital department
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- School based health services
- Skilled nursing facility
- Surgical services
- Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)
- Vision services
- Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP)

Member Copays

FAMIS does not have yearly or monthly premiums. However, children who are enrolled in a MCO must pay co-payments for some covered services. There are no co-payments required for preventative services such as well-child care, immunizations, or dental care. The chart below shows the co-payment amounts for some basic FAMIS services for children who are enrolled in a MCO, based on co-pay status.

NOTE: Native Americans and Alaskan Natives do NOT have any co-payments.

SERVICE*	Co-pay Status 1	Co-pay Status 2
Outpatient Hospital or Doctor	\$2 per visit	\$5 per visit
Prescription Drugs	\$2 per prescription	\$5 per prescription
Inpatient Hospital	\$15 per admission	\$25 per admission
Non-emergency use of Emergency Room	\$10 per visit	\$25 per visit
Yearly Co-payment Limit per Family	\$180	\$350

*Other co-payments may apply to other services.

Member Eligibility Card

A blue and white plastic eligibility card is issued to members to present to participating providers. Plan First members receive a green and white identification card. **The provider is obligated to determine that the person to whom care or service is being rendered is the same individual listed on the eligibility card.** The provider has the responsibility to request such identification as he or she deems necessary. Presentation of a plastic ID card is not proof of coverage nor guarantee of payment. A sample of an eligibility card is included under “Exhibits” at the end of this chapter.

Eligibility must be confirmed each time service is rendered. Verification can occur through a verification vendor, the voice response system or the web-based verification system. LDSS do not provide verification of eligibility to providers.

Some individuals have coverage under a Virginia Medicaid/FAMIS contracted managed care organization (MCO) and should not receive services outside their network without a referral and authorization from the MCO. These members will have an MCO card in addition to the Medicaid/FAMIS card. The verification response will advise if the member has restrictions such as a contracted MCO enrollment, or a primary payer.

The provider must determine if the service is within the dates of eligibility. These dates must be checked prior to rendering any service. Benefits are available only for services performed during the indicated period of eligibility; Medicaid/FAMIS will not pay for care or services rendered before the beginning date or after the end date of eligibility.

Bank Identifier

The top six numbers on the plastic card represent the Bank Identifier Number (BIN), which is required for pharmacy benefit cards under the National Council of Prescription Drug Programs (NCPDP).

Name of Eligible Person

An eligibility card is issued to each person eligible for full Medicaid/FAMIS benefits and QMBs. Members enrolled in Plan First receive a green and white identification card. Check the name against another proof of identification if there is any question that the card does not belong to the

member.

Member's Eligibility Number

The member's complete eligibility number is embossed on the front of the eligibility card. Eligibility numbers are distinct and permanent. When a member relocates or moves into another case, or has a break in eligibility, he keeps the same number and the same card. When members are enrolled in Plan First, they will receive a green and white identification card. This number serves as a “key” in verifying current eligibility status.

All 12 digits must be entered on Medicaid forms for billing purposes.

Date of Birth

The date of birth indicates the member's age and identifies eligibility for those services with age restrictions, such as dental care for members under age 21 and pregnant women. The date of birth should be checked prior to rendering any services. The provider should verify the age of the member. If the provider has a question as to the age of the member, means of identification other than the Medicaid/FAMIS card should be examined.

Sex

The member's gender is indicated on the card.

Card #

The sequential number of the member's card is given. If a card is lost or stolen and another Manual Title All Manuals Chapter III Page 7 Chapter Subject Member Eligibility Page Revision Date 02/22/2019 is issued, the prior card will be de-activated and will not confirm eligibility using the magnetic “swipe” mechanism.

Cardholder's Signature (signature line on back)

The signature line provides another element of verification to confirm identity

Verification of Member Eligibility

It is the obligation of the provider of care to determine the identity of the person named on the eligibility card and the current eligibility status, to include program type or MCO enrollment. It is in the best interest of the provider to review the card each time services are rendered. Possession of a card does not mean the holder is currently eligible for benefits. The member does not relinquish the card when coverage is cancelled. Replacement cards must be requested.

Program/Benefit Package Information

Members' benefits vary depending upon the program in which they are enrolled. The eligibility verification will provide information on which program the member is participating in. Examples of these programs include Medallion 3.0, Medicaid fee-forservices, FAMIS MCO, CCC Plus, FAMIS fee-for-service and Medicare premium payment.

Limited Benefit Programs for Which Members Receive Eligibility Cards

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid

Programs to expand the coverage of services to QMBs. There are two levels of coverage for QMBs, based on financial eligibility.

QMB Coverage Only—Members in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit, less the member's copayment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY--QMB." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage—Members in this group are dually-eligible for full Medicaid coverage and Medicare. They are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. This group's Medicaid verification provides the message, "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED." These members are responsible for copays for pharmacy services, health department clinic visits, and vision services.

SLMBs and QIs do not receive member eligibility cards because they are not eligible for the payment of medical services rendered.

Plan First—Men and women enrolled in Plan First can receive limited Medicaid covered family planning services only, and they receive a green and white plastic Plan First identification card. This group's Medicaid verification provides the message, "PLAN FIRST - FAMILY PLANNING SERVICES ONLY." See the Plan First Manual for more information.

All Others—Members without ANY of these messages at time of verification will be eligible for those covered services listed in Chapter I of this manual.

Special Indicator Code (Copayment Code)

The Special Indicator Code indicates the status of copayments or eligibility for certain additional services. These codes are:

Code	Message
A	Under 21 - No copay exists.
B	Individuals Receiving Long-Term Care Services, Home or Community-Based Waiver Services, or Hospice Care - No copay is required for any service.
C	All Other Members - Copays apply for inpatient hospital admissions, outpatient hospital clinic visits, clinic visits, physician office visits, other physician visits, eye examinations, prescriptions, home health visits, and rehabilitation service visits. (Some verification methods may return a yes/no response. Yes = copays apply. No = copays do not apply)

The following copay exemptions apply:

- Members in managed care organizations may not have to pay copays.
- Pregnancy-related services or family planning clinic visits, drugs, and supplies are exempt from copays for all members.
- No copayments apply for any emergency services for any member, with one exception for members in Client Medical Management with a pharmacy restriction. Please refer to the Client Medical Management exhibit in Chapter I for more information on this exception.

The Medicaid member co-pays are located in Chapter IV.

The FAMIS member co-pays are:

Service*	Co-pay Status 1	Co-pay Status 2
Outpatient Hospital or Doctor	\$2 per visit	\$5 per visit
Prescription Drugs	\$2 per prescription	\$5 per prescription
Inpatient Hospital	\$15 per admission	\$25 per admission
Non-emergency use of Emergency Room	\$10 per visit	\$25 per visit
Yearly Co-payment Limit per Family	\$180	\$350

*Other co-payments may apply to other services.

Insurance Information The "Insurance Information" in the verification response indicates any type of insurance coverage the member has in addition to Medicaid. This information includes specific insurance companies, dates of coverage, policy numbers, and a code that specifies the particular type of coverage of the policy. These items are:

Carrier Code	A three-digit code indicating the name of the insurance carrier, e.g. 001 for Medicare (See Insurance Company Code List for these code numbers in "EXHIBITS" at the end of this chapter.) If the carrier code is 003 (not listed), call the member's local eligibility worker for assistance in obtaining the name of the insurance carrier.
Begin Date	The first date on which this insurance policy was effective
Type Code	An alpha character describing the type of coverage provided by the policy, such as a "D" for dental coverage. (See the Type of Coverage Code List under "EXHIBITS" at the end of this chapter for a list of these codes.)
Policy Number/ Medicare Code	The specific policy or Medicare number for the insurance identified by the Carrier Code

Only insurance information for active policies during the period for which eligibility is requested is provided at verification. If the member reports insurance information different from what is on the card, refer the member to his or her LDSS eligibility worker to correct the data so bills will be processed correctly.

Under the assignment of benefits regulations, DMAS can act on behalf of the member (subscriber) and recover third-party payment from the primary carrier. Workers' Compensation and other

liability insurances (e.g., automobile liability insurance or home accident insurance) are always considered as primary carriers for cases where coverage is applicable to the injury being treated. Because the member's eligibility card cannot indicate this coverage, it is necessary that cause-of-injury information be obtained from the member.

Primary Care Providers (PCPs) for the Client Medical Management Program

A primary care designation or restriction is imposed by the Member Monitoring Unit of DMAS as a result of high utilization of services by the member causing unnecessary or duplicate services. Eligibility verification will list the names of designated primary care providers (physician and/or pharmacy). The designated providers must agree to the relationship prior to the designation appearing on the member's card. Unless it is an emergency, do not provide services without contacting the primary care provider first for authorization.

Managed Care Programs

Most Medicaid members are enrolled in one of the Department's managed care programs (Medallion 3.0, Medallion 4.0, CCC Plus, PACE). Each program has specific eligibility requirements and health plan assignment criteria for its members. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact and/or eligibility and assignment information for managed care plans can be found on the DMAS website for each program as follows:

- Medallion 3.0:
<http://www.dmas.virginia.gov/#/med3>
- Medallion 4.0:
<http://www.dmas.virginia.gov/#/med4>
- Commonwealth Coordinated Care Plus (CCC Plus):
<http://www.dmas.virginia.gov/#/cccplus>
- Program of All-Inclusive Care for the Elderly (PACE):
<http://www.dmas.virginia.gov/#/longtermprograms>

Member Without an Eligibility Card

A member who seeks services without a current eligibility card should be considered responsible for all charges incurred unless eligibility is verified. The provider can verify eligibility without the card using two other identification keys, including name, Social Security Number, and date of birth. These can be used to access the MediCall automated System, the verification vendors, and the web verification system (ARS). See Chapter I for further information about verification methods. LDSS do not provide verification of eligibility to providers.

Assistance to Patients Possibly Eligible for Benefits

If a patient is unable to pay for services rendered, the provider may refer the patient or the patient's authorized representative to the LDSS in the locality in which the applicant resides or to the Cover

Virginia Call Center at 1-855-242-8282 for an application for health care coverage. The LDSS or Cover Virginia will notify the patient of eligibility or ineligibility. Medicaid assumes no financial responsibility for services rendered prior to the effective date of a member's eligibility. The effective date of Medicaid eligibility may be retroactive up to three months prior to the month in which the application was filed, if the patient was eligible during the retroactive period. Once a patient is found eligible, providers may bill Medicaid for covered services, and upon receipt of payment from Medicaid, must reimburse the patient for the out-of-pocket expenses; Medicaid does not reimburse members for out-of-pocket expenses.

Medicaid Applications -- Authorized Representative Policy

Medicaid eligibility requirements are strict and require an applicant or someone conducting business on his or her behalf to attest to citizenship or alien status, declare all income and assets, and make assignment of insurance and medical support benefits. In order to accurately determine eligibility, LDSS must ensure that an individual who files an application or someone conducting business on behalf of the applicant has full knowledge of the applicant's situation and can provide correct information.

A Medicaid applicant must sign the application form unless the application is filed and signed by the applicant's legal guardian or conservator, attorney-in-fact, or other person who is authorized to apply on the applicant's behalf. If the applicant is unable to sign his or her name but can make a mark, the mark must be designated "his/her mark" and witnessed by one person.

A child under age 18 cannot legally sign a Medicaid application for himself or herself unless he or she is legally emancipated from his or her parents. If a child is not legally emancipated, his or her parent or legal guardian, an authorized representative designated by the parent or legal guardian, or a caretaker relative with whom the child lives must sign the application. Exception: A minor child under 18 years of age may apply for Medicaid on behalf of his or her own child.

A legally competent individual age 18 or older may authorize anyone age 18 or older to file a Medicaid application on his or her behalf provided that the authorization is in writing, identifies the individual or organization authorized to conduct business on his or her behalf, and is signed by the individual giving the authorization.

When an individual has been determined by a court to be legally incompetent or legally incapacitated, the individual's legally appointed guardian or conservator is the individual's authorized representative and can apply for Medicaid on the individual's behalf. If an individual does not have a legal guardian or authorized representative and is mentally unable to sign an application or designate a representative, the individual's spouse will be considered the authorized representative for Medicaid purposes. In situations where the individual is not married, is estranged from his or her spouse, or the spouse is unable to represent him or her, a relative of the individual who is willing to take responsibility for the individual's Medicaid business may be considered his or her authorized representative. Relatives who may be considered authorized representatives in this situation are, in the following order of preference: the individual's adult child; parent; adult sibling; adult niece or nephew; or adult aunt or uncle.

If it is determined that an individual cannot sign an application and does not have an attorney in-fact

or authorized representative, a Medicaid application may be filed by someone other than an authorized person provided the individual's inability to sign the Medicaid application is verified by a written statement from the individual's doctor. The statement must indicate that the individual is unable to sign and file a Medicaid application because of his or her diagnosis or condition. The LDSS will pend the application until it can be appropriately signed if it is determined that court action has been initiated to have a guardian or committee appointed for the individual or until an Adult Protective Services investigation concludes that guardianship proceedings will not be initiated. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of an individual who cannot designate an authorized representative.

An application may be filed on behalf of a deceased person by his or her guardian or conservator, attorney-in-fact, executor or administrator of his or her estate, surviving spouse, or a surviving family member, in the following order of preference: adult child, parent, adult sibling, adult niece or nephew, or adult aunt or uncle. The application must be filed within a three-month period subsequent to the month of the individual's death. Medicaid coverage can be effective no earlier than three months prior to the application month. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

Non-Medicaid Patient Relationship

Medicaid-eligible members who elect to be treated as private patients or who decline to verify their Medicaid eligibility with providers will be treated as private pay patients by the provider and by DMAS. Providers are required to furnish supporting documentation whenever patients fall into either of these categories.

Newborn Infant Eligibility

All newborn days, including claims for "well babies," must be submitted separately. "Well baby" days cannot be processed as part of the mother's per diem, and no information related to the newborn must appear on the mother's claim.

A newborn is automatically considered eligible for Medicaid or FAMIS through age 1 year if the newborn's mother was eligible for full coverage Medicaid or enrolled in FAMIS or FAMIS MOMS at the time she gave birth. A medical assistance application must be filed for any child whose mother was not eligible for Medicaid or enrolled in FAMIS/FAMIS MOMS at the time of the child's birth.

An easy, streamlined way for hospitals to report the birth of the newborn is through the Medicaid Web Provider Portal www.virginiamedicaid.dmas.virginia.gov under the link "E213". Any hospital staff that have approval from their hospital and have access to the portal may report the newborn's birth and receive the newborn's Member ID within 2 business days via email. The provider can verify newborn eligibility from the card using two other identification keys, including name, social security number, and the date of birth. These can be used to access MediCall, the verification vendors, and the web-based system, ARS.

See Chapter I: [General Information](#) for more information on eligibility verification.

Medicaid Eligibility for Hospice Services

To be eligible to elect hospice as a Medicaid benefit, an individual must be entitled to Medicaid benefits and be certified as terminally ill. "Terminally ill" is defined as having a medical prognosis that life expectancy is six months or less. If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected or revoked concurrently under both programs.

Guidelines on Institutional Status

Federal regulations in 42 CFR 435.1009 prohibit federal financial participation in Medicaid services provided to two groups of individuals in institutions; these individuals are NOT eligible for Medicaid:

- individuals who are inmates of a public institution, and
- individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. A psychiatric residential treatment facility for children and adolescents is an IMD. An Intermediate Care Facility for the Intellectually Disabled (ICF-ID) is not an IMD.

Inmates of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole.

An individual is considered incarcerated until permanent release, bail, probation or parole. An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid. The following are ineligible public institutions:

- public residential institutions with more than 16 beds
- residential facilities located on the grounds of, or adjacent to, a public institution with more than 16 beds.

Incarcerated Individuals

Incarcerated individuals (adults and juveniles) who are hospitalized can be eligible for Medicaid payment limited to services received during an inpatient hospitalization of 24 hours or longer, provided they meet all other Medicaid eligibility requirements.

Incarcerated individuals include:

- individuals under the authority of the Virginia Department of Corrections (DOC) or Virginia Department of Juvenile Justice (DJJ), and
- individuals held in regional and local jails, including those on work release.

Individuals are not eligible for full benefit Medicaid coverage while they are living in a correctional facility, regional or local jail or juvenile facility.

An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

Once an individual is released from the correctional facility, he can be enrolled in full benefit Medicaid, provided he meets all Medicaid eligibility requirements.

Juveniles

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention, pre- and postdisposition situations, and types of facilities.

a. Prior to Court Disposition

The following juveniles can be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

- Juvenile who is in a detention center due to criminal activity
- Juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution and can only be eligible for Medicaid payment limited to inpatient hospitalization. A list of secure detention facilities in Virginia is available on the Department of Juvenile Justice's web

site: http://www.djj.virginia.gov/Residential_Programs/Secure_Detention/pdf/Detention_Home_Contacts_02242011rev.pdf.

If they go to a non-secure group home, they can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center. A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to Medical Insurance Security (FAMIS) coverage.

c. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible for full-benefit Medicaid if he/she is a resident of an ineligible public residential facility. He can be eligible for Medicaid coverage limited to inpatient hospitalization if he is admitted to a medical facility for inpatient services.

Who is Not an Inmate of a Public Institution

An individual is NOT an inmate of a public institution if:

- The individual is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- The individual is in a public institution for a temporary period pending other arrangements appropriate to his needs. Individuals in public institutions for a temporary period include:
 - individuals admitted under a TDO
 - individuals arrested then admitted to a medical facility
 - inmates out on bail
 - individuals on probation (including a juvenile on conditional probation or probation in a secure treatment center), parole, or conditional release
 - juveniles in a detention center due to care, protection or in their best interest.

Member Appeals

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid member or by an authorized representative on behalf of the member. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. Members who are enrolled in an MCO may appeal to the MCO or directly to DMAS. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was sent, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the member may be expected to repay DMAS for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable. If services are continued or reinstated due to an appeal, the provider may not terminate or reduce services until a decision is rendered by the hearing officer.

Member appeals must be requested in writing and postmarked or submitted within 30 days of receipt of the notice of adverse action. The member or his authorized representative may complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488.

If the member is not able to get the form, he may write a letter. The letter must include the name of



the person whose request for benefits was denied, reduced, or cancelled. Also, the letter must include the person's date of birth, social security number, case number, the agency that took the action, and the date of the action.

A copy of the notice or letter about the adverse action should be included with the appeal request. The appeal request must be sent to the:

Appeals Division

Department of Medical Assistance Services

600 E. Broad Street, 6th Floor
Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 452-5454

The Appeals Division will notify members of the date, time and location of the hearing if the appeal is valid and a hearing is granted. The hearing will be conducted by a DMAS Hearing Officer. Most hearings will be done by telephone.

The Hearing Officer's decision is the final administrative decision by DMAS. If the member does not agree with the Hearing Officer's decision, he/she may appeal it directly to the circuit court in the city or county of residence.

Covered Services and Limitations (Lab)

Covered Services (Lab)

General Information

The Commonwealth of Virginia's State Plan for Medical Assistance provides coverage for "other laboratory and X-ray services." This includes services provided by independent laboratories for all recipients eligible under the Medicaid Program. The category "other laboratory and X-ray services" means professional and technical laboratory and radiological services. These services are to be ordered by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law.

A physician's direction or certification is required for the coverage of independent laboratory services.

DMAS requires the use of Health Care Financing Administration Common Procedure Coding System (HCPCS) codes and codes and definitions published in the most recent Physicians' Current Procedural Terminology (CPT) in billing for covered services. The CPT manual may be obtained from:

Order Department: OP054192

American Medical Association

P. O. Box 10950

Chicago, IL 60610

Coverage

Payment for laboratory and x-ray services will be made directly to the provider actually performing the service (i.e., physician, independent laboratory, or other participating facility). The laboratory may bill for the handling and/or conveyance of specimens sent to another laboratory by using CPT/HCPCS procedure code 99001. Only one specimen handling fee is allowed per specimen. Laboratory procedures performed by outside sources at no charge to the practitioner or laboratory are not to be billed to Medicaid.

Whenever laboratory tests are performed that are generally part of a profile, the maximum payment is the appropriate automated profile rate, regardless of how the specimen is tested. This includes, but is not limited to, chemistry and hematology testing:

- The CPT/HCPCS coding system delineates tests that are frequently done as part of a chemistry profile. When two or more of these lab tests are performed on the same specimen, in any combination, the lesser automated rate is to be billed regardless of how the specimen is tested. CPT/HCPCS codes 80002-80019 are to be used, and the code used must correlate with the number of tests performed. Only one panel code is to be used per specimen. If only one procedure is performed, use the appropriate CPT/HCPCS procedure code which describes the individual test.
- Whenever **four** or more components of a hemogram are performed, the appropriate hemogram CPT/HCPCS code is to be used (85021-85031). CPT/HCPCS codes 85021-85030 are to be used when specimens are tested using automated equipment, and CPT/HCPCS code 85031 is to be used when specimens are tested manually.

If fewer than four components of a hemogram are performed, they are to be billed using the appropriate individual CPT/HCPCS codes.

Payment for the following tests will be made only to a pathologist, hospital laboratory, or a participating laboratory. Specimens for the tests listed below may also be sent to the State Laboratory:

86171 Complement fixation tests, each (e.g., cat scratch fever, coccidioidomycosis, histoplasmosis, psittacosis, rubella, streptococcus MG, syphilis)

87116 Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); any source, isolation only

87117 Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); concentration plus

isolation

87118 Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); definitive identification, per organism (does not include isolation and/or concentration)

87190 Sensitivity studies, antibiotic; tubercle bacillus (TB, AFB), each drug

87250 Virus, inoculation of embryonated eggs, suitable tissue culture, or small animal, includes observation and dissection

Screening Mammography

Screening mammography of asymptomatic women for the early detection of breast cancer is covered according to the schedule below. Claims for mammography services for women determined to be at high risk, according to accepted medical practices that are performed at the screening frequency for high risk, must be coded for unusual service (Code 22) and must include an attachment providing a brief explanation of the high-risk condition.

Age	Risk Category	Screening Frequency
35-39	All Women	One screening mammogram (baseline)
40-49	Low Risk	One mammogram every other year (At least 23 months must have elapsed since the month of the last screening)
40-49	High Risk	One mammogram each year (At least 11 months must have elapsed since the month of the last screening.)
50 and over	All Women	All women One mammogram each year (At least 11 months must have elapsed since the month of the last screening.)

Limitations

The following laboratory service specifically excluded from coverage and payment:

- Sensitivity studies when a culture shows no growth or urine cultures with contaminant growth (103 or less) - Payment will be made only for the culture.

Payment for Services (Lab)

General Information

DMAS will pay only the independent laboratory or hospital for laboratory and x-ray services ordered by a physician and performed by the laboratory or hospital. Funds are not available to pay a physician for any laboratory or x-ray service performed by the laboratory or hospital.

Payment Methodology

The Deficit Reduction Act of 1984 requires Medicare to establish fee schedules for clinical laboratory procedures, including specimen handling and collection. Federal regulations (42 CFR 447.342) limit Medicaid reimbursement to no more than the amount allowed by Medicare for the same procedure. Therefore, Medicaid reimbursement for clinical laboratory procedures will not exceed the Medicare fee schedule. In the past, some laboratory fees exceeded the Medicare allowance. Effective for dates of service on and after January 1, 1998, laboratory fees that exceed what Medicare allowance will be reduced to the Medicare rate.

Payment for laboratory services is the **lowest of**:

- The Program's fee schedule;
- The provider's charges; or
- The National Clinical Laboratory fee cap, implemented July 1, 1986.

Federal regulation 42 CFR 447.15 requires providers to accept Medicaid payment as payment in full for the service required.

Cost Sharing

Services billed by independent laboratories are not subject to the cost-sharing requirements applicable to some other services provided under the Virginia Medicaid Program. Therefore, independent laboratories must not collect copayments from Medicaid recipients.

Third-Party Liability

Since Medicaid is always the payer of last resort, the provider is required to seek payment from any other sources where the recipient may have coverage for the services provided before billing Medicaid. Information regarding other sources can be obtained from the recipient or from the Medicaid ID card. Information showing payments collected from other sources must be included on the Medicaid invoice. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

Insurance information and the recipient's 12-digit eligibility number should be supplied by the physician ordering the laboratory or x-ray service.

The Deficit Reduction Act of 1984 requires independent and hospital laboratories to accept Medicare assignment. The Medicare intermediary/carrier will pay the lesser of 100 percent of the fee schedule amount (no coinsurance or deductible is applied) or the allowable charge by the provider for all assigned claims for clinical laboratory procedures. **Medicaid is the payer of last resort.** The Medicare payment of 100 percent of the Medicare fee schedule or 100 percent of charges, whichever is less, is a third-party source of payment for clinical laboratory procedures. Therefore, independent laboratories should accept Medicare assignment for clinical laboratory procedures with no billings to Virginia Medicaid for these procedures where the patient is Medicare/Medicaid-eligible.

The Medicaid Program will not make payments for a recipient covered by Workers' Compensation.

Liability Insurance For Accidental Injuries

The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of injuries caused by the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medicaid Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in the Virginia Code Section 8.01-66.9.

When the provider bills and accepts payment by Virginia Medicaid in liability cases, the provider, under federal regulations, must accept Virginia Medicaid payment as payment in full. However, providers can initially choose to bill the third-party carrier or file a lien in lieu of billing Virginia Medicaid.

Medicare Catastrophic Coverage Act of 1988

[Effective Date: January 1989]

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to certain low income Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMBs).

QMB Coverage Only

Recipients in this group are eligible only for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit, less the recipient's copayment, on allowed charges for **all** Medicare-covered services. They will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY--QMB-- MEDICAID PAYMENT LIMITED TO MEDICARE COINSURANCE AND DEDUCTIBLE." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage

Recipients in this group will be eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for **all** Medicare-covered services **plus** coverage of **all** other Medicaid-covered services listed in Chapter I of this

manual. This group will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED."

All Others

Recipients without either of these messages on their Medicaid cards will be eligible for those covered services listed in Chapter I of this manual.

Submission of Claims for Nonresident Aliens

Chapters I and III contain information on the coverage and eligibility requirements for nonresident aliens. To submit a claim for covered emergency services for a nonresident alien :

- Complete the appropriate Medicaid billing form (and any other required forms) in the usual manner.
- Attach a copy of the completed Emergency Medical Certification Form to the invoice. Other relevant documentation to justify the approval has already been submitted and reviewed and therefore does not need to be duplicated with this claim.
- Submit the claim using the preprinted envelopes supplied by Medicaid or by mailing the claim directly to the appropriate post office box.

NOTE: The same procedures apply for adjusted or voided claims.

All claims for nonresident aliens will pend for certification to verify that they were related to the emergency situation which has been approved. All claims not related to the emergency treatment will be denied. The documentation for a denied claim will be kept by Medicaid for 180 days from the date of receipt to allow for the appeal process for those services which are not approved.

Billing Procedures (Lab)

The purpose of this chapter is to explain the documentation procedures for billing the Virginia Medicaid Program.

Two major areas are covered in this chapter:

- General Information - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.
- Billing Procedures - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

Electronic Submission of Claims

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system



Independent Laboratory

directly. For more information contact our fiscal agent,

Conduent:

Phone: (866)-352-0766

Fax number: (888)-335-8460

Website: <https://vamedicaid.dmas.virginia.gov/edi> or by mail

Conduent:

EDI Coordinator

Virginia Medicaid Fiscal Agent

P.O. Box 26228

Richmond, Virginia 23260-6228

Billing Instructions: Direct Data Entry

As part of the 2011 General Assembly Appropriation Act - 300H which requires that all new providers bill claims electronically and receive reimbursement via Electronic Funds Transfer (EFT) no later than October 1, 2011 and existing Medicaid providers to transition to electronic billing and receive reimbursement via EFT no later than July 1, 2012, DMAS has implemented the Direct Data Entry (DDE) system. Providers can submit claims quickly and easily via the Direct Data Entry (DDE) system. DDE will allow providers to submit Professional (CMS-1500), Institutional (UB-04) and Medicare Crossover claims directly to DMAS via the Virginia Medicaid Web Portal. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQs can be accessed from our web portal at: www.vamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider.

(This Section is under Review - March 2022)

Timely Filing

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations [42 CFR § 447.45(d)] to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of

service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. Submission is defined as actual, physical receipt by DMAS. In cases where the actual receipt of a claim by DMAS is undocumented, it is the provider's responsibility to confirm actual receipt of a claim by DMAS within 12 months from the date of the service reflected on a claim. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

Retroactive Eligibility - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

Delayed Eligibility - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted. The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Denied claims - Denied claims must be submitted and processed **on or before thirteen months from date of the initial denied claim where the initial claim was filed within the 12 months limit to be** considered for payment by Medicaid. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.
- **Attach** written documentation to justify/verify the explanation. This documentation may be continuous denials by Medicaid or any dated follow-up correspondence from Medicaid showing that the provider has actively been submitting or contacting Medicaid on getting the claim processed for payment. Actively pursuing claim payment is defined as documentation of contacting DMAS at least every six months. Where the provider has failed to contact DMAS for six months or more, DMAS shall consider the resubmission to be untimely and no further action shall be taken. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits).

Accident Cases - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursement.

Other Primary Insurance - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service**. If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursements. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

Other Insurance - The member can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid member. For members with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while the member has Medicaid without penalty from their insurance company. The members must notify the insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

Submit the claim in the usual manner by mailing the claim to billing address noted in this chapter.

Billing Instructions: Billing Invoices (Lab)

The requirements for submission of physician billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below is the billing invoice to be used:

- Health Insurance Claim Form, CMS-1500 (02-12)

If submitting on paper, the requirement to submit claims on an original CMS-1500 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice.

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid

Billing Instructions: Automated Crossover Claims Processing (Lab)

Most claims for dually eligible members are automatically submitted to DMAS. The Medicare claims processor will submit claims based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as “crossovers” since

the claims are automatically crossed over from Medicare to Medicaid.

To make it easier to match to providers to their Virginia Medicaid provider record, providers are to begin including their Virginia Medicaid ID as a secondary identifier on the claims sent to Medicare. When a crossover claim includes a Virginia Medicaid ID, the claim will be processed by DMAS using the Virginia Medicaid number rather than the Medicare vendor number. This will ensure the appropriate Virginia Medicaid provider is reimbursed.

When providers send in the 837 format, they should instruct their processors to include the Virginia Medicaid provider number and use qualifier “1D” in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the Virginia Medicaid ID on the original claim to Virginia Medicare will reduce the need for submitting follow-up paper claims. DMAS has established a special email address for providers to submit questions and issues related to the Virginia Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmass.virginia.gov.

Billing Instructions: Requests for Billing Materials

Health Insurance Claim Form CMS-1500 (02-12)

The CMS-1500 (02-12) is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Print Office
Superintendent of Documents
Washington, DC 20402
(202) 512-1800 (Order and Inquiry Desk)

Note: The CMS-1500 (02-12) will not be provided by DMAS.

The request for other forms or billing supplies must be submitted by:

1. Mailing the request to: Commonwealth Martin 1700 Venable St. Richmond, VA 23223
2. Calling the DMAS order desk at Commonwealth Martin at 804-780-0076, or
3. Faxing the DMAS order desk at Commonwealth Martin at 804-780-0198

All orders must include the following information:

- Provider Identification Number
- Company Name and Contact Person
- Street Mailing Address (No Post Office Numbers are accepted)
- Telephone Number and Extension of the Contact Person
- The form number and name of the form
- The quantity needed for each form

Please DO NOT order excessive quantities.



Independent Laboratory

Direct any requests for information or questions concerning the ordering of forms to the address above or call Commonwealth Martin at (804)780-0076.

Claim Inquiries and Reconsideration

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services

Department of Medical Assistance Services

600 East Broad Street, Suite 1300
Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long-distance (toll-free)

Member verification and claim status may be obtained by telephoning:

1-800- 772-9996	Toll-free throughout the United States
1-800- 884-9730	Toll-free throughout the United States
1-804- 965-9732	Richmond and Surrounding Counties
1-804- 965-9733	Richmond and Surrounding Counties

Member verification and claim status may also be obtained by utilizing the Web-based Automated Response System. See Chapter I for more information.

Billing Instructions: Billing Procedures (AAL)

Physicians and other practitioners must use the appropriate claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services Practitioner
P.O. Box 27444
Richmond, Virginia 23261-7444
Or



Independent Laboratory

Department of Medical Assistance Services
CMS Crossover
P. O. Box 27444
Richmond, Virginia 23261-7444

Billing Instructions: Electronic Filing Requirements

DMAS is fully compliant with 5010 transactions and will no longer accept 4010 transactions after March 30, 2012.

The Virginia MMIS will accommodate the following EDI transactions according to the specification published in the Companion Guide version 5010

270/271 Health Insurance Eligibility Request/ Response Verification for Covered Benefits (5010)

276/277 Health Care Claim Inquiry to Request/ Response to Report the Status of a Claim (5010)

277 - Unsolicited Response (5010)

820 - Premium Payment for Enrolled Health Plan Members (5010)

834 - Enrollment/ Disenrollment to a Health Plan (5010)

835 - Health Care Claim Payment/ Remittance (5010)

837 - Dental Health Care Claim or Encounter (5010)

837 - Institutional Health Care Claim or Encounter (5010)

837 - Professional Health Care Claim or Encounter (5010)

NCPDP - National Council for Prescription Drug Programs Batch (5010)

NCPDP - National Council for Prescription Drug Programs POS (5010) Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

All 5010/D.0 Companion Guides are available on the web portal:

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides> or contact EDI Support at 1-866-352-0766 or Virginia.EDISupport@conduent.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

For providers that are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: <https://www.virginiamedicaid.dmas.virginia.gov>.

Billing Instructions: ClaimCheck

Effective June 3, 2013, DMAS implemented the Medicaid National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) and Medically Unlikely Edits (MUE) edits. This implementation was in response to directives in the Affordable Care Act of 2010. These new edits will impact all Physicians, Laboratory, Radiology, Ambulatory Surgery Centers, and Durable Medical Equipment and Supply providers. Effective January 1, 2014, all outpatient hospital claims will be subject the NCCI edits thru the EAPG claim processing. Please refer to the Hospital Manual, Chapter 5 for details related to EAPG. The NCCI/ClaimCheck edits are part of the daily claims adjudication cycle on a concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All NCCI/ClaimCheck edits are based on the following global claim factors: same member, same servicing provider, same date of service or the date of service is within established pre- or post-operative time frame. All CPT and HCPCS code will be subject to both the NCCI and ClaimCheck edits. Upon review of the denial, the provider can re-submit a corrected claim. Any system edits related to timely filing, etc. are still applicable.

- **PTP Edits**

CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an accepted Medicaid NCCI modifier. Note: Prior to this implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.

- **MUE Edits**

DMAS implemented the Medicaid NCCI MUE edits. These edits define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single date of service and by same servicing provider. The MUEs apply to the number of units allowed for a specific procedure code, per day. If the claim units billed exceed the per day allowed, the claim will deny. With the implementation of the MUE edits, providers must bill any bilateral procedure correctly. The claim should be billed with one unit and the 50 modifier. The use of two units will subject the claim to the MUE, potentially resulting in a denial of the claim. Unlike the current ClaimCheck edit which denies the claim and creates a claim for one unit, the Medicaid NCCI MUE edit will deny the entire claim.

- **Exempt Provider Types**

DMAS has received approval from CMS to allow the following provider types to be exempt from the Medicaid NCCI editing process. These providers are: Community Service Boards (CSB), Federal Health Center (FQHC), Rural Health Clinics (RHC), Schools and Health Departments. These are the only providers exempt from the NCCI/editing process. All other providers billing on the CMS 1500 will be subject to these edits.

- **Service Authorizations**

DMAS has received approval from CMS to exempt specific CPT/HCPCS codes which require a valid service authorization. These codes are exempt from the MUE edits however, they are still subject to the PTP and ClaimCheck edits.

- **Modifiers**

Prior to this implementation, DMAS allowed claim lines with modifiers 24, 25, 57, 59 to bypass the CCI/ClaimCheck editing process. With this implementation, DMAS now only allows the Medicaid NCCI associated modifiers as identified by CMS for the Medicaid NCCI. The modifier indicator currently applies to the PTP edits. The application of this modifier is determined by the modifier indicator of “1” or “0” in the listing of the NCCI PTP column code. If the column one, column two code combination has a modifier indicator of “1”, a modifier is allowed and both codes will pay. If the modifier indicator is “0”, the modifier is not allowed and the column two code will be denied. The MUE edits do not contain a modifier indicator table on the edit table. Per CMS, modifiers may only be applied if the clinical circumstances justify the use of the modifier. A provider cannot use the modifier just to bypass the edit. The recipient’s medical record must contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. DMAS or its agent will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: E1 -E4, FA, F1 - F9, TA T1 - T9, LT, RT, LC, LD, RC, LM, RI, 24, 25, 57, 58, 78, 79, 27, 59, 91. Modifiers 22, 76 and 77 are not Medicaid PTP NCCI approved modifiers. If these modifiers are used, they will not bypass the Medicaid PTP NCCI edits.

RECONSIDERATION

Providers that disagree with the action taken by a ClaimCheck/NCCI edit may request a reconsideration of the process via email (ClaimCheck@dmass.virginia.gov) or by submitting a request to the following mailing address:

Payment Processing Unit, Claim
Check

Division of Program Operations

Department of Medical Assistance
Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

There is a 30-day time limit from the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an

approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

Billing Instructions Reference for Services Requiring Service Authorization

Please refer to the “Service Authorization” section in Appendix D of this manual.

CLIA Certification (LEA)

Any laboratory claims submitted by local education agencies will be denied if no CLIA certificate and identification number is on file with DMAS. This requirement implements the federal Clinical Laboratory Improvement Amendment of 1988. To obtain a CLIA certificate and number or to obtain information about CLIA, call or write the Virginia Department of Health (VDH) at:

VDH Office of Health Facility Regulation

3600 Centre, Suite 216

3600 W. Broad Street

Richmond, Virginia 23230

804-367-2104

DMAS will deny claims for services outside of the CLIA certificate type, edit reason 480 (provider not CLIA certified to perform procedure).

Billing Instructions: Instructions For Use of the CMS-1500 (02-12), Billing Form

The Direct Data Entry (DDE) CMS-1500 claim form on the Virginia Medicaid Web Portal will be updated to accommodate the changes to locators 21 and 24E on 4/1/2014. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ's can be accessed from our web portal at:

www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider. Paper claim submissions should only be submitted when requested specifically by DMAS.

To bill for services, the Health Insurance Claim Form, CMS-1500 (02-12), invoice form must be used for paper claims received on or after April 1, 2014. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12). The purpose of the CMS-1500 (02-12) is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid members.

SPECIAL NOTES: The provider number in locator 24J must be the same in locator 33 unless the Group/Billing Provider relationship has been established and approved by DMAS for use.

Locator		Instructions
1	REQUIRED	Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Detention Order (EDO).
1a	REQUIRED	Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	REQUIRED	Patient's Name - Enter the name of the member receiving the service.
3	Not Required	Patient's Birth Date (DOB)
4	Not Required	Insured's Name
5	Not Required	Patient's Address
6	Not Required	Patient Relationship to Insured
7	Not Required	Insured's Address
8	Not Required	Reserved for NUCC Use
9	Not Required	Other Insured's Name
9a	Not Required	Other Insured's Policy or Group Number
9b	Not Required	Reserved for NUCC Use
9c	Not Required	Reserved for NUCC Use
9d	Not Required	Insurance Plan Name or Program Name
10	REQUIRED	Is Patient's Condition Related To: Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state postal code should be entered if known.
10d	Conditional	Claim Codes (Designated by NUCC) Enter "ATTACHMENT" if documents are attached to the claim forms.
11	Not Required	Insured's Policy Number or FECA Number
11a	Not Required	Insured's Date of Birth
11b	Not Required	Other Claim ID

11c	REQUIRED If applicable	Insurance Plan or Program Name Providers that are billing for non-Medicaid MCO copays only please insert "HMO Copay".
11d	REQUIRED If applicable	Is There Another Health Benefit Plan? Providers should only check yes, if there is other third party coverage.
12	Not Required	Patient's or Authorized Person's Signature
13	Not Required	Insured's or Authorized Person's Signature
14	REQUIRED If applicable	Date of Current Illness, Injury, or Pregnancy Enter date MM DD YY format Enter Qualifier 431 - Onset of Current Symptoms or Illness
15	Not Required	Other Date
16	Not Required	Dates Patient Unable to Work in Current Occupation
17	REQUIRED If applicable	Name of Referring Physician or Other Source - Enter the name of the referring physician.
17a	REQUIRED If applicable	I.D. Number of Referring Physician - The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b	REQUIRED If applicable	I.D. Number of Referring Physician - Enter the National Provider Identifier of the referring physician.
18	Not Required	Hospitalization Dates Related to Current Services
19	REQUIRED If applicable	Additional Claim Information Enter the CLIA #.
20	Not Required	Outside Lab
21 A-L	REQUIRED	Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. Note: ICD Ind. Not required at this time. 9= ICD-9-CM 0=ICD-10-CM
22	REQUIRED If applicable	Resubmission Code - Original Reference Number. Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
23	REQUIRED If applicable	Service Authorization (SA) Number - Enter the SA number for approved services that require a service authorization.

NOTE: The locators 24A thru 24J have been divided into open areas and a shaded line area. The shaded area is ONLY for supplemental information. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. ENTER



REQUIRED INFORMATION ONLY.

24A lines 1-6 open area	REQUIRED	Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01/01/14). DATES MUST BE WITHIN THE SAME MONTH
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<p>24A lines 1- 6 red shaded</p>	<p>REQUIRED If applicable</p>	<p>DMAS requires the use of qualifier 'TPL'. This qualifier is to be used whenever an actual payment is made by a third party payer. The 'TPL' qualifier is to be followed by the dollar/cents amount of the payment by the third party carriers. Example: Payment by other carrier is \$27.08; red shaded area would be filled as TPL27.08. No spaces between qualifier and dollars. No \$ symbol but the decimal between dollars and cents is required.</p> <p>DMAS requires the use of the qualifier 'N4'. This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS drug-related code is submitted in 24D to DMAS. No spaces between the qualifier and the NDC number.</p> <p>NOTE: DMAS is requiring the use of the Unit of Measurement Qualifiers following the NDC number for claims received on and after May 26, 2014. The unit of measurement qualifier code is followed by the metric decimal quantity Unit of Measurement Qualifier Codes:</p> <ul style="list-style-type: none"> • F2 - International Units • GR - Gram • ML - Milliliter • UN - Unit <p>Examples of NDC quantities for various dosage forms as follows:</p> <ul style="list-style-type: none"> • Tablets/Capsules - bill per UN • Oral Liquids - bill per ML • Reconstituted (or liquids) injections - bill per ML • Non-reconstituted injections (I.E. vial of Rocephin powder) - bill as UN (1 vial = 1 unit) • Creams, ointments, topical powders - bill per GR • Inhalers - bill per GR <p>BILLING EXAMPLES:</p> <p><u>TPL, NDC and UOM submitted:</u> TPL3.50N412345678901ML1.0</p> <p><u>NDC, UOM and TPL submitted:</u> N412345678901ML1.0TPL3.50</p> <p><u>NDC and UOM submitted only:</u> N412345678901ML1.0</p> <p><u>TPL submitted only:</u> TPL3.50</p> <p><u>Note: Enter only TPL, NDC and UOM information in the supplemental shaded area. (see billing examples) All supplemental information is to be left justified.</u></p> <p>SPECIAL NOTE: DMAS will set the coordination of benefit code based on information supplied as followed:</p> <ul style="list-style-type: none"> • If there is nothing indicated or 'NO' is checked in locator 11d, DMAS will set that the patient had no other third party carrier. This relates to the old coordination of benefit code 2. • If locator 11d is checked 'YES' and there is nothing in the locator 24a red shaded line; DMAS will set that the third party carrier was billed and made no payment. This relates to the old coordination of benefit code 5. An EOB/documentation must be attached to the claim to verify non payment. • If locator 11d is checked 'YES' and there is the qualifier 'TPL' with payment amount (TPL15.50), DMAS will set that the third party carrier was billed and payment made of \$15.50. This relates to the old coordination of benefit code 3.
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24B open area	REQUIRED	Place of Service - Enter the 2-digit CMS code, which describes where the services were rendered.
24C open area	REQUIRED If applicable	Emergency Indicator - Enter either 'Y' for YES or leave blank. DMAS will not accept any other indicators for this locator.
24D open area	REQUIRED	Procedures, Services or Supplies - CPT/HCPCS - Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable.
24E open area	REQUIRED	Diagnosis Code - Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered. Claims with values other than A-L in Locator 24-E or blank may be denied.
24F open area	REQUIRED	Charges - Enter your total usual and customary charges for the procedure/services.
24G open area	REQUIRED	Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period.
24H open area	REQUIRED If applicable	EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service
24 I open	REQUIRED If applicable	NPI - This is to identify that it is a NPI that is in locator 24J
24 I	REQUIRED If applicable	ID QUALIFIER -The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier '1D' is required for the API entered in locator 24J red shaded line.
24J open	REQUIRED If applicable	Rendering provider ID# - Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J redshaded	REQUIRED If applicable	Rendering provider ID# - The qualifier '1D' is required for the API entered in this locator. The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line.
25	Not Required	Federal Tax I.D. Number
26	REQUIRED	Patient's Account Number - Up to FOURTEEN alphanumeric characters are acceptable.
27	Not Required	Accept Assignment
28	REQUIRED	Total Charge - Enter the total charges for the services in 24F lines 1-6

29	REQUIRED If applicable	Amount Paid - For personal care and waiver services only - enter the patient pay amount that is due from the patient. NOTE: The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.
30	Not Required	Rsvd for NUCC Use
31	REQUIRED	Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.
32	REQUIRED if applicable	Service Facility Location Information - Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. NOTE: For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
32a open	REQUIRED if applicable	NPI # - Enter the 10 digit NPI number of the service location.
32b red shaded	REQUIRED if applicable	Other ID#: - The qualifier '1D' is required for the API entered in this locator. The qualifier of 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 32a open line.
33	REQUIRED	Billing Provider Info and PH # - Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid. NOTE: Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
33a	REQUIRED	NPI - Enter the 10 digit NPI number of the billing provider.
33b red shaded	REQUIRED	Other Billing ID - The qualifier '1D' is required for the API entered in this locator. The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 33a open line. NOTE: DO NOT use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

Service Type Description	Taxonomy Code
Renal Unit	261QE0700X

**Instructions for the Completion of the
Health Insurance Claim Form, CMS-1500
(02-12), as an Adjustment Invoice**

The Adjustment Invoice is used to change information on an approved claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator	Medicaid Resubmission
22	Code - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.
	1023 Primary Carrier has made additional payment
	1024 Primary Carrier has denied payment
	1025 Accommodation charge correction
	1026 Patient payment amount changed
	1027 Correcting service periods
	1028 Correcting procedure/service code
	1029 Correcting diagnosis code
	1030 Correcting charges
	1031 Correcting units/visits/studies/procedures
	1032 IC reconsideration of allowance, documented
	1033 Correcting admitting, referring, prescribing, provider identification number
	1053 Adjustment reason is in the Misc. Category



Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 (02-12) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim)

NOTE: ICNs can only be adjusted through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services Attn: Fiscal &
Procurement Division, Cashier 600 East Broad St. Suite
1300

Richmond, VA 23219

Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (02-12), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator 22	Medicaid Resubmission	
	Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.	
	1042	Original claim has multiple incorrect items
	1044	Wrong provider identification number
	1045	Wrong enrollee eligibility number
	1046	Primary carrier has paid DMAS maximum allowance
	1047	Duplicate payment was made
	1048	Primary carrier has paid full charge
	1051	Enrollee not my patient
	1052	Miscellaneous
	1060	Other insurance is available
	<u>Original Reference Number/ICN</u> - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only <u>one</u> claim can be voided on each CMS-1500 (02-12) submitted as a <u>Void Invoice</u> . (Each line under Locator 24 is one claim).	

NOTE: ICNs can only be voided through the Virginia MMIS up

to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services Attn: Fiscal &
Procurement Division, Cashier 600 East Broad St. Suite
1300

Richmond, VA 23219

Group Practice Billing Functionality

Providers defined in this manual are not eligible to submit claims as a Group Practice with the Virginia Medicaid Program. Group Practice claim submissions are reserved for independently enrolled fee-for-service healthcare practitioners (physicians, podiatrists, psychologists, etc.) that share the same Federal Employer Identification Number. Facility-based organizations (NPI Type 2) and providers assigned an Atypical Provider Identifier (API) may not utilize group billing functionality.

Medicare Crossover: If Medicare requires you to submit claims identifying an individual Rendering Provider, DMAS will use the Billing Provider NPI to adjudicate the Medicare Crossover Claim. You will not enroll your organization as a Group Practice with Virginia Medicaid.

For more information on Group Practice enrollment and claim submissions using the CMS- 1500 (02-12), please refer to the appropriate practitioner Provider Manual found at www.dmas.virginia.gov.



Billing Instructions: Special Note Taxonomy (Lab)

With the implementation of the National Provider Identifier (NPI), it will become necessary in some cases to include a taxonomy code on claims submitted to DMAS for all of our programs: Medicaid, FAMIS, and SLH. Prior to using the NPI, DMAS assigned a unique number to a provider for each of the service types performed. But with NPI, a provider may only have one NPI and bill for more than one service type with that number. Since claims are adjudicated and paid based on the service type, our system must determine which service type the provider intended to be assigned to a particular claim. If the NPI can represent more than one service type, a taxonomy code must be sent so the appropriate service type can be assigned.

Code	Description
282N00000X	Hospital Laboratory
291U00000X	Clinical Medical Laboratory
293D00000X	Physiological Laboratory

Billing Instructions: Negative Balance Information

Negative balances occur when one or more of the following situations have occurred:

- Provider submitted adjustment/void request
- DMAS completed adjustment/void
- Audits
- Cost settlements
- Repayment of advance payments made to the provider by DMAS

In the remittance process the amount of the negative balance may be either off set by the total of the

approved claims for payment leaving a reduced payment amount or may result in a negative balance to be carried forward. The remittance will show the amount as “less the negative balance” and it may also show “the negative balance to be carried forward.”

The negative balance will appear on subsequent remittances until it is satisfied. An example is if the claims processed during the week resulted in approved allowances of \$1000.00 and the provider has a negative balance of \$2000.00. A check will not be issued, and the remaining \$1000.00 outstanding to DMAS will carry forward to the next remittance.

Billing Instructions: Special Billing Instructions -- Client Medical Management Program

The primary care provider (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter 1 under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre- authorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary care provider or on referral from the primary care provider must place the primary care provider's NPI in locator 17b or the API in Locator 17a with the qualifier '1D'and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. The name of the referring PCP must be entered in locator 17.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a “Y” in Locator 24C and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
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10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70.
17	Enter the name of the referring primary care provider.
17a red shaded	When a restricted enrollee is treated on referral from the primary physician, enter the qualifier '1D' and the appropriate provider number (current Medicaid or an API) (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d. Note: Please refer to the time line for the appropriate provider number as indicated in main instruction above.
17b open	When a restricted enrollee is treated on referral from the primary physician, enter the NPI number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d. Note: This locator can only be used for claims received on or after March 26, 2007.
24C	When a restricted enrollee is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "Y" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10D.

Billing Instructions: EDI Billing (Electronic Claims)

Please refer to X-12 Standard Transactions & our Companion Guides that are listed in the chapter.

Billing Instructions: Instructions for Completing the Paper CMS-1500 (02-12) Form for Medicare and Medicare Advantage Plan Deductible, Coinsurance

and Copay Payments for Professional Services (Effective 11/02/2014)

The Direct Data Entry (DDE) Crossover Part B claim form is on the Virginia Medicaid Web Portal. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ's can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider. Paper claim submissions should only be submitted when requested specifically by DMAS.

Purpose:	A method of billing Medicare's deductible, coinsurance and copay for professional services received by a Medicaid member in the Virginia Medicaid program on the CMS 1500 (02-12) paper claim form. The CMS1500 (02-12) claim form must be used to bill for services received by a Medicaid member in the Virginia Medicaid program. The following instructions have numbered items corresponding to fields on the CMS1500 (02-12)
NOTE:	Note changes in locator 11c and 24A lines 1-6 red shaded area. These changes are specific to Medicare Part B billing only.

Locator	Instructions	
1	REQUIRED	Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Custody Order (ECO).
1a	REQUIRED	Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	REQUIRED	Patient's Name - Enter the name of the member receiving the service.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Reserved for NUCC Use
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	REQUIRED	Is Patient's Condition Related To: - Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state should be entered if known.
10d	Conditional	Claim Codes (Designated by NUCC) Enter "ATTACHMENT" if documents are attached to the claim form. Medicare/Medicare Advantage Plan EOB should be attached.
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	REQUIRED	Insurance Plan or Program Name Enter the word ' CROSSOVER ' IMPORTANT: DO NOT enter 'HMO COPAY' when billing for Medicare/Medicare Advantage Plan copays! Only enter the word ' CROSSOVER '
11d	REQUIRED If Applicable	Is There Another Health Benefit Plan? If Medicare/Medicare Advantage Plan and Medicaid only, check "NO". Only check "Yes", if there is additional insurance coverage other than Medicare/Medicare Advantage Plan and Medicaid.
12	NOT REQUIRED	Patient's or Authorized Person's Signature



Independent Laboratory

13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy Enter date MM DD YY format Enter Qualifier 431 - Onset of Current Symptoms or Illness
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	NOT REQUIRED	Name of Referring Physician or Other Source - Enter the name of the referring physician.
17a shaded red	NOT REQUIRED	I.D. Number of Referring Physician - The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b	NOT REQUIRED	I.D. Number of Referring Physician - Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	NOT REQUIRED	Additional Claim Information Enter the CLIA #.
20	NOT REQUIRED	Outside Lab?
21 A-L	REQUIRED	Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. Note: ICD Ind. Not required at this time.

22	REQUIRED If Applicable	<p>Resubmission Code - Original Reference Number. Required for adjustment or void. Enter one of the following resubmission codes for an adjustment:</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr><td>1023</td><td>Primary Carrier has made additional payment</td></tr> <tr><td>1024</td><td>Primary Carrier has denied payment</td></tr> <tr><td>1025</td><td>Accommodation charge correction</td></tr> <tr><td>1026</td><td>Patient payment amount changed</td></tr> <tr><td>1027</td><td>Correcting service periods</td></tr> <tr><td>1028</td><td>Correcting procedure/ service code</td></tr> <tr><td>1029</td><td>Correcting diagnosis code</td></tr> <tr><td>1030</td><td>Correcting charge</td></tr> <tr><td>1031</td><td>Correcting units/visits/studies/procedures</td></tr> <tr><td>1032</td><td>IC reconsideration of allowance, documented</td></tr> <tr><td>1033</td><td>Correcting admitting, referring, prescribing, provider identification number</td></tr> <tr><td>1053</td><td>Adjustment reason is in the Misc. Category</td></tr> </tbody> </table> <p>Enter one of the following resubmission codes for a void:</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr><td>1042</td><td>Original claim has multiple incorrect items</td></tr> <tr><td>1044</td><td>Wrong provider identification number</td></tr> <tr><td>1045</td><td>Wrong enrollee eligibility number</td></tr> <tr><td>1046</td><td>Primary carrier has paid DMAS maximum allowance</td></tr> <tr><td>1047</td><td>Duplicate payment was made</td></tr> <tr><td>1048</td><td>Primary carrier has paid full charge</td></tr> <tr><td>1051</td><td>Enrollee not my patient</td></tr> <tr><td>1052</td><td>Miscellaneous</td></tr> <tr><td>1060</td><td>Other insurance is available</td></tr> </tbody> </table> <p>Original Reference Number - Enter the claim reference number/ICN of the Virginia Medicaid paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted or voided. Only one paid claim can be adjusted or voided on each CMS-1500 (02-12) claim form. (Each line under Locator 24 is one claim).</p> <p>NOTE: ICNs can only be adjusted or voided through the Virginia MMIS up to three years from the date the claim was paid. After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted or voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:</p> <ul style="list-style-type: none"> • A cover letter on the provider's letterhead which includes the current address, contact name and phone number. • An explanation about the refund. • A copy of the remittance page(s) as it relates to the refund check amount. • Mail all information to: Department of Medical Assistance Services Attn: Fiscal & Procurement Division, Cashier 600 East Broad St., Suite 1300 Richmond, VA 23219 <p>Prior Authorization (PA) Number - Enter the PA number for approved services that require a service authorization.</p> <p>NOTE: The locators 24A thru 24J have been divided into open and shaded line areas. The shaded area is ONLY for supplemental information. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. ENTER REQUIRED INFORMATION ONLY.</p>	Code	Description	1023	Primary Carrier has made additional payment	1024	Primary Carrier has denied payment	1025	Accommodation charge correction	1026	Patient payment amount changed	1027	Correcting service periods	1028	Correcting procedure/ service code	1029	Correcting diagnosis code	1030	Correcting charge	1031	Correcting units/visits/studies/procedures	1032	IC reconsideration of allowance, documented	1033	Correcting admitting, referring, prescribing, provider identification number	1053	Adjustment reason is in the Misc. Category	Code	Description	1042	Original claim has multiple incorrect items	1044	Wrong provider identification number	1045	Wrong enrollee eligibility number	1046	Primary carrier has paid DMAS maximum allowance	1047	Duplicate payment was made	1048	Primary carrier has paid full charge	1051	Enrollee not my patient	1052	Miscellaneous	1060	Other insurance is available
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24A lines 1-6 open area	REQUIRED	<p>Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01 01 14).</p>																																														

24A-H lines 1- 6 red shaded	REQUIRED If Applicable	<p>NEW INFORMATION! DMAS is requiring the use of the following qualifiers in the red shaded for Part B billing:</p> <ul style="list-style-type: none"> • A1 = Deductible (Example: A120.00) = \$20.00 ded • A2 = Coinsurance (Example: A240.00) = \$40.00 coins • A7= Copay (Example: A735.00) = \$35.00 copay • AB= Allowed by Medicare/Medicare Advantage Plan (Example AB145.10) = \$145.10 Allowed Amount • MA= Amount Paid by Medicare/Medicare Advantage Plan (Example MA27.08) see details below • CM= Other insurance payment (not Medicare/Medicare Advantage Plan) if applicable (Example CM27.08) see details below • N4 = National Drug Code (NDC)+Unit of Measurement <p>'MA': This qualifier is to be used to show Medicare/Medicare Advantage Plan's payment. The 'MA' qualifier is to be followed by the dollar/cents amount of the payment by Medicare/Medicare Advantage Plan Example: Payment by Medicare/Medicare Advantage Plan is \$27.08; enter MA27.08 in the red shaded area</p> <p>'CM': This qualifier is to be used to show the amount paid by the insurance carrier other than Medicare/Medicare Advantage plan. The 'CM' qualifier is to be followed by the dollar/cents amount of the payment by the other insurance. Example: Payment by the other insurance plan is \$27.08; enter CM27.08 in the red shaded area</p> <p>NOTE: No spaces are allowed between the qualifier and dollars. No \$ symbol is allowed. The decimal between dollars and cents is required.</p> <p>DMAS is requiring the use of the qualifier 'N4'. This qualifier is to be used for the National Drug Code (NDC) whenever a drug related HCPCS code is submitted in 24D to DMAS. The Unit of Measurement Qualifiers must follow the NDC number. The unit of measurement qualifier code is followed by the metric decimal quantity or unit. Do not enter a space between the unit of measurement qualifier and NDC. Example: N400026064871UN1.0</p> <p>Any spaces unused for the quantity should be left blank.</p> <p>Unit of Measurement Qualifier Codes:</p> <ul style="list-style-type: none"> • F2 - International Units • GR - Gram • ML - Milliliter • UN - Unit <p>Examples of NDC quantities for various dosage forms as follows:</p> <ol style="list-style-type: none"> Tablets/Capsules - bill per UN Oral Liquids - bill per ML Reconstituted (or liquids) injections - bill per ML Non-reconstituted injections (I.E. vial of Rocephin powder) - bill as UN (1 vial = 1 unit) Creams, ointments, topical powders - bill per GR Inhalers - bill per GR <p>Note: All supplemental information entered in locator 24A thru 24H is to be left justified.</p> <p>Examples:</p> <ol style="list-style-type: none"> Deductible is \$10.00, Medicare/Medicare Advantage Plan Allowed Amt is \$20.00, Medicare/Medicare Advantage Plan Paid Amt is \$16.00, Coinsurance is \$4.00. - Enter: A110.00 AB20.00 MA16.00 A24.00 Copay is \$35.00, Medicare/Medicare Advantage Plan Paid Amt is \$0.00 Medicare/Medicare Advantage Plan Allowed Amt is \$100.00 - Enter: A735.00 MA0.00 AB100.00 Medicare/Medicare Advantage Plan Paid Amt is \$10.00, Other Insurance payment is \$10.00, Medicare/Medicare Advantage Plan Allowed Amt is \$10.00, Coinsurance is \$5.00, NDC is 12345678911, Unit of measure is 2 grams - Enter: MA10.00 CM10.00 AB10.00 A25.00 N412345678911GR2 <p>**Allow a space in between each qualifier set**</p>
24B open area	REQUIRED	Place of Service - Enter the 2-digit CMS code, which describes where the services were rendered.
24C open area	REQUIRED If applicable	Emergency Indicator - Enter either 'Y' for YES or leave blank. DMAS will not accept any other indicators for this locator.
24D open area	REQUIRED	Procedures, Services or Supplies - CPT/HCPCS - Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable.
24E open area	REQUIRED	Diagnosis Code - Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered. Claims with values other than A-L in Locator 24-E or blank will be denied.
24F open area	REQUIRED	Charges - Enter the Medicare/Medicare Advantage Plan billed amount for the procedure/services. NOTE: Enter the Medicare/Medicare Advantage Plan Copay amount as the charged amount when billing for the Medicare/Medicare Advantage Plan Copay ONLY.
24G open area	REQUIRED	Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period.
24H open area	REQUIRED If applicable	EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service
24I open	REQUIRED If applicable	NPI - This is to identify that it is a NPI that is in locator 24J
24 I redshaded	REQUIRED If applicable	ID QUALIFIER -The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier '1D' is required for the API entered in locator 24J red shaded line.
24J open	REQUIRED If applicable	Rendering provider ID# - Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J redshaded	REQUIRED If applicable	Rendering provider ID# - If the qualifier '1D' is entered in 24I shaded area enter the API in this locator. If the qualifier 'ZZ' was entered in 24I shaded area enter the provider taxonomy code if the NPI is entered in locator 24J open line.
25	NOT REQUIRED	Federal Tax I.D. Number
26	REQUIRED	Patient's Account Number - Up to FOURTEEN alphanumeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	REQUIRED	Total Charge - Enter the total charges for the services in 24F lines 1-6

29	REQUIRED If applicable	Amount Paid - For personal care and waiver services only - enter the patient pay amount that is due from the patient. NOTE: The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.
30	NOT REQUIRED	Rsvd for NUCC Use
31	REQUIRED	Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.
32	REQUIRED If applicable	Service Facility Location Information - Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. NOTE: For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
32a open	REQUIRED If applicable	NPI # - Enter the 10 digit NPI number of the service location.
32b red shaded	REQUIRED If applicable	Other ID#: - The qualifier '1D' is required with the API entered in this locator. The qualifier of 'ZZ' is required with the provider taxonomy code if the NPI is entered in locator 32a open line.
33	REQUIRED	Billing Provider Info and PH # - Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid. NOTE: Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
33a open	REQUIRED	NPI - Enter the 10 digit NPI number of the billing provider.
33b red shaded	REQUIRED If applicable	Other Billing ID - The qualifier '1D' is required with the API entered in this locator. The qualifier 'ZZ' is required with the provider taxonomy code if the NPI is entered in locator 33a open line. NOTE: DO NOT use commas, periods, space, hyphens or other punctuations between the qualifier and the number. The information may be typed (recommend font Sans Serif 12) or legibly handwritten. Retain a copy for the office files. Mail the completed claims to: Department of Medical Assistance Services CMS Crossover P. O. Box 27444 Richmond, Virginia 23261-7444

Invoice Processing (PP)

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a crossreference number, and entered into the system, it is placed in one of the following categories:

- Remittance Voucher
 - **Approved** - Payment is approved or pended.
 - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
 - **Pend** - Payment is pended for claim to be manually reviewed by DMAS staff or waiting on further information from provider.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.

Please use this link to search for DMAS Forms:

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch>

Instructions for the Completion of the DMAS-3 Form

THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 1234567890701200312345.) IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** - Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. Do not enter spaces, dashes or slashes or any special characters.
2. **Date of Service** - Enter the from date of service the attachment applies to.
3. **Sequence Number** - Enter the provider generated sequence number up to 5 digits only.
4. **Provider Number** - Enter the Medicaid Provider number.
5. **Provider Name** - Enter the name of the Provider.
6. **Enrollee Identification Number** - Enter the Medicaid ID number of the Enrollee.
7. **Enrollee Last Name** - Enter the last name of the Enrollee.
8. **First** - Enter the first name of the Enrollee.
9. **MI** - Enter the middle initial of the Enrollee.
10. **Type of Attachment** - Check the type of attachment or specify.
11. **Comment** - Enter comments if necessary.
12. **Authorized Signature** - Signature of the Provider or authorized Agent.
13. **Date Signed** - Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number. Mailing addresses are available in the Provider manuals or check the DMAS website at www.dmas.virginia.gov.

Utilization Review and Control (Lab)

Under the provisions of federal regulations, the Medical Assistance Program must

provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by recipients. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

Financial Review and Verification

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction. DMAS and the MCOs will perform the financial review and verification of services for their contracted providers to ensure that the provider bills for services consistent with the DMAS policy as well as with the provider's contract with the MCO.

Compliance Reviews (Lab)

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455. Providers and recipients are identified for review by systems generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases using available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Statistical sampling and extrapolation may be used in a review. The Department may use a random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample are compared to the total invalid payments for the same time period, and the total amount of the overpayment is estimated from this

sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, Medicaid may restrict or terminate the provider's participation in the program.

Fraudulent Claims

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Since payment of claims is made from both State and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or State court. The Program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable State and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 692-0480



Independent Laboratory

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit

Office of the Attorney General

900 E. Main Street, 5th Floor

Richmond, Virginia 23219

Recipient Fraud

Allegations regarding issuance of non-entitled benefits and/or fraud and abuse by nonproviders are investigated by the Recipient Audit Unit of DMAS. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid and/or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card-sharing and prescription forgeries.

If it is determined that non-entitled benefits were issued, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia State Plan for Medical Assistance, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of 12 months beginning with the month of the fraud conviction. The sanction period may only be revoked or shortened by court order.

Referrals should be made to:

Supervisor, Recipient Audit Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-0156

Referrals to the Client Medical Management Program (PP)

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical

Assistance Services. Referred clients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and pharmacy in the Client Medical Management (CMM) Program. See “Exhibits” at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate clients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voice mail receives after-hours referrals. Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit Division
of Program Integrity

Department of Medical Assistance Services 600
East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

Fax: (804) 371-8891

When making a referral, provide the name and Medicaid number of the client and a brief statement about the nature of the utilization problems. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Appendix C: Service Authorization Information (Lab)

Service authorization (Srv Auth) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require Srv Auth and some may begin prior to requesting authorization.

Purpose of Service Authorization

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's

continued Medicaid/FAMIS eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity. Medallion 3 MCO-enrolled members are subject to service authorization requirements of the individual's MCO.

General Information Regarding Service Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for Srv Auth requests.


The Srv Auth entity will approve, pend, reject, or deny all completed Srv Auth requests. Requests that are pending or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider is notified in writing of the status of the request.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care (MCO) program, the Srv Auth entity will honor the Medicaid MCO service authorization if the client has been retroactively disenrolled from the MCO. Similarly, the MCO will honor the Srv Auth Contractor's authorization based upon proof of authorization from the provider, DMAS, or the Srv Auth Contractor that services were authorized while the member was eligible under fee-for-service (not MCO enrolled) for dates where the member has subsequently become enrolled with a DMAS contracted MCO. Srv Auth decisions by the DMAS Srv Auth Contractor are based upon clinical review and apply only to individuals enrolled in Medicaid fee-for-service on dates of service requested. The Srv Auth Contractor decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify member eligibility and to check for managed care organization (MCO) enrollment. For MCO enrolled members, the provider must follow the MCO's Srv Auth policy and billing guidelines.

Commonwealth Coordinated Care Plus (CCC Plus) Program

Members Transitioning into CCC Plus

 For members that transition into the CCC Plus Program, the CCC Plus Health Plan will honor the Srv Auth contractor's authorization for a period of not less than 90 days or until the Srv Auth ends whichever is sooner, for providers that are in-and out-of-

network.

When a member enrolls in CCC Plus, the provider should contact the CCC Plus Health Plan to obtain an authorization and information regarding billing for services if they have not been contacted the CCC Plus Health Plan.

Members Transitioning from CCC Plus and Back to Medicaid Fee-For Service (FFS)

Should a member transition from CCC Plus to Medicaid FFS, the provider must submit a request to the Srv Auth Contractor and needs to advise the Srv Auth Contractor that the request is for a CCC Plus transfer within 60 calendar days. This will ensure honoring of the approval for the continuity of care period and waiving of timeliness requirements. The Srv Auth Contractor will honor the CCC Plus approval up to the last approved date but no more than 60 calendar days from the date of CCC Plus disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the SA Contractor will apply medical necessity/service criteria.

Should the request be submitted to the Srv Auth Contractor after the continuity of care period:

- A. The dates of service within the continuity of care period will be honored for the 60-day timeframe;
- B. The dates of service beyond the continuity of care period, timeliness will be waived and reviewed for medical necessity, all applicable criteria will be applied on the first day after the end of the continuity of care period
- C. For CCC Plus Waiver Services, cap hours will be approved the day after the end of the continuity of care period up to the date of request. The continuation of service units will be dependent upon service criteria being met and will either be authorized or reduced accordingly as of the date of the request.

The best way to obtain the most current and accurate eligibility information is for providers to do their monthly eligibility checks at the *beginning* of the month. This will provide information for members who may be in transition from CCC Plus at the very end of the previous month.

Should there be a scenario where DMAS has auto closed (ARC 1892) the SA Contractor's service authorization but the member's CCC Plus eligibility has been retro-voided, continuity of care days will not be approved by the CCC Plus health plan and will not be on the transition reports since the member never went into CCC Plus. The SA Contractor will re-open the original service authorization for the same provider upon provider notification.

CCC Plus Exceptions:

The following exceptions apply:

- If the service is not a Medicaid covered service, the request will be rejected;
- If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized; the Srv Auth Contractor will honor the CCC Plus approved days/units under the continuity of care period for up to 60 calendar days. The remaining dates of services will be reviewed and must meet service criteria but timeliness will be waived as outlined above.)
- If the service has been authorized under CCC Plus for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once member is FFS, only Medicaid approved services will be honored for the continuity of care.
- If a member transitions from CCC Plus to FFS, and the provider requests an authorization for a service not previously authorized under CCC Plus, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the Srv Auth Contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

DMAS has published multiple Medicaid memos that can be referred to for detailed CCC Plus information. For additional information regarding CCC Plus, click on the link: http://www.dmas.virginia.gov/Content_pgs/mltss-home.

The Governor's Access Plan (GAP) (Fee-for-Service Members)

Some GAP members will remain in fee-for-service and will receive their medical service authorization through DMAS' Service Authorization Contractor, Keystone Peer Review Organization (KEPRO). The services received through fee-for-service will not change from the current GAP services. These members will **not** receive the new Medicaid Expansion benefits and will continue to use their GAP identification card through March 31, 2019, when the GAP program ends. KEPRO will accept requests for GAP (medical) services through March 31, 2019 at 11:59 pm. Requests received on and after April 1, 2019 will be rejected.

The Governor's Access Plan (GAP) for medical and behavioral health services is restricted to Virginia adults (ages 21 through 64) who have a serious mental illness. The GAP benefit plan includes limited medical coverage where some of these services require service authorization through DMAS' Service Authorization Contractor, Keystone Peer Review Organization (KEPRO). Service authorization is required for the

following Traditional medical services:

- Non-emergent, outpatient Magnetic Resonance Imaging (MRI scan) *
- Non-emergent, outpatient Computerized Axial Tomography (CAT scan) *
- Durable Medical Equipment: limited to overage Diabetic Supplies only
- Surgical Procedures (specific procedure codes only)
- Medical Device Services/Maintenance (specific procedure/HCPCS codes only)

*Only services performed in outpatient facility settings. All others limited to physician's office only. Physician office includes Health Department Clinics, Rural Health Clinics (RHC), and Federally Qualified Health Clinics (FQHC).

Should a service require service authorization under the GAP benefit plan, providers must submit a request according to the specific service type standards to meet the timeliness requirements (when appropriate) as well as medical documentation to meet the service specific criteria.

The specific DME diabetic supply codes covered by GAP are included in the Durable Medical Equipment and Supplies Manual, Appendix B, "Diabetic Products" section. Providers should review Chapter IV and Appendix B to determine medical necessity criteria, the allowable amount for each code (no service authorization required) and any overage amount that requires service authorization.

Refer to KEPRO's website <http://dmas.kepro.com/> for procedure codes and HCPCS codes that are included in the GAP benefit and require service authorization by KEPRO. All codes are subject to change so providers must refer to KEPRO's website for any updates. Information may be found on the DMAS website, Service Authorization section, at the following link:
http://www.dmas.virginia.gov/Content_pgs/pa-home.aspx.

For general GAP information, refer to the GAP Supplement C found on the DMAS web portal, Provider Services, Provider Manuals section. The GAP link also provides useful information: http://www.dmas.virginia.gov/Content_pgs/GAP.aspx.

Communication (Lab)

Provider manuals are located on the DMAS web portal and KePRO websites. The contractor's website has information related to the service authorization processes for programs identified in this manual. You may access this information by going to <http://dmas.kepro.com> and clicking on the Forms tab for questionnaires and fax forms to request services. A service specific checklist may be found by clicking on "Service Authorization Checklists" on KEPRO's website. For educational material, click on the Training tab and scroll down to click on the General or Outpatient tab.

The service authorization entity provides communication and language needs for non- English

speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing. Updates or changes to the Srv Auth process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

Service Authorization Process (Lab)

Effective August 1, 2003, the Department of Medical Assistance Services (DMAS) implemented a mandatory service authorization process for all non-emergency, planned and scheduled, outpatient Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiograph (MRA), Computerized Axial Tomography (CAT), and Positron Emission Tomography (PET) scans. These service authorization requirements apply to all Medicaid clients enrolled in fee-for-service, as well as FAMIS clients enrolled in fee-for-service or Primary Care Case Management (PCCM) programs and must be completed prior to the scan being performed. These requirements do not apply to these scans when performed during an inpatient hospitalization or as an emergency through the hospital's emergency room. The following information outlines the procedures for obtaining service authorization and reimbursement for these non-emergency, outpatient scans at in state facilities only. For out-of-state facilities, refer to the section titled, "**Specific Information for Out-of-State Providers.**"

DMAS has contracted with (Keystone Peer Review Organization (KePRO) to conduct medical appropriateness reviews utilizing InterQual® ISX criteria, a McKesson Health Solutions, LLC product. To request service authorization, contact KePRO. For information regarding the service authorization submission process, refer to the "Submitting Requests for Service Authorizations" section in Appendix C.

****Effective November 1, 2016, out-of-state non emergent MRI, CT, Scan and PET Scans must be submitted to DMAS Medical Support Unit. KEPRO WILL CONTINUE to review Virginia in state Imaging.**

It is the responsibility of the ordering physician or his/her representative, the hospital or outpatient facility or radiologist to contact KePRO for Virginia In state Imaging Provider request **ONLY** and provide the necessary information and medical appropriate indications for the specific type of scan being ordered.

Upon receipt of the case, a reviewer will reassess the information against InterQual® ISX (Indications for Imaging Studies and X-rays) criteria. If the case information satisfies the criteria, an approval is given for the requested diagnostic test. If the documentation submitted does not satisfy the criteria, a referral will be made to a peer reviewer for the determination.

If the patient has Medicare Part B, service authorization is not required unless Medicare has been billed and denied. Likewise, if the Medicare benefits are exhausted, the health care provider must submit a Srv Auth request for retrospective review within 30 days of the notice of denial or exhaustion by Medicare. If the patient has been determined to be eligible for Medicaid covered services retrospectively, and his/her coverage is made retroactive to include the scanning date of service, the ordering physician or his/her representative, the hospital or outpatient facility or radiologist must contact KePRO for retrospective authorization from Virginia in state Providers **ONLY**. Prior to billing Medicaid the provider must have a Srv Auth. The health care provider should

request a Srv Auth for retrospective review within 30 days of the notice of Medicaid eligibility.

For recipients with other third party coverage (other than Medicare), the ordering physician or his/her representative, the hospital or outpatient facility or radiologist must contact KePRO prior to the scan for a service authorization from Virginia in state Providers ONLY. There will be no retrospective reviews done for recipients with other third party coverage since the service authorization from Medicaid is to occur before the scan is done. Urgent scans that are performed prior to obtaining service authorization must be retrospectively authorized. The definition of an urgent scan is when the ordering physician identifies an urgent need to have a scan performed the same day as seen by the physician. The physician sends the patient immediately to the hospital or outpatient facility to have the scan performed. The ordering physician or his/her representative, the hospital or outpatient facility or radiologist must contact KePRO for retrospective authorization within one business day of the scan being performed, when requested by Virginia in state Providers. When contacting KePRO to perform retrospective review, notify KePRO that Medicare Part B has been denied, or that the patient has retroactive eligibility, or that the scan was performed on an urgent basis and provide the necessary information and medical appropriateness indications for the scan that has already been performed.

Submitting Requests for Service Authorization (Lab)

DMAS' Service Authorization Contractor, KePRO, is moving to their own Provider Portal "Atrezzo Connect" effective October 31, 2011 at 6:00 a.m. The previous system (iEXCHANGE™) will not be available to providers, effective 5:00 p.m., October 28, 2011. For direct data entry requests, providers must begin using the new Atrezzo Connect Provider Portal. The new Atrezzo Connect Provider Portal advantages include easier system changes when DMAS program changes occur and specific prompts and edits related to certain programs in the new system. DMAS-related information from the previous system will be transferred into KePRO's new Atrezzo Connect Provider Portal prior to October 31, 2011.

The registration process for providers is much simpler and quicker than with iEXCHANGE™ and happens immediately on-line. Existing iEXCHANGE™ users can log onto Atrezzo Connect without re-registering, using a special username consisting of their iEXCHANGE™ group ID, a hyphen, and their iEXCHANGE™ username. The initial password is also the iEXCHANGE™ group ID. They will then be given a one-time opportunity to change their username and password. Users from providers not currently registered with iEXCHANGE™ will select a username and password and then establish their legitimate connection to the selected NPI# by providing information taken from the most recent remittance advice. After logging in, Group administrators and Administrators within Atrezzo can specify other users within their organization and establish preferences for servicing providers, diagnoses and procedure codes. The Atrezzo Connect User Guide is available at dmas.kepro.com: Click on the Training tab, then the General tab.

Providers with questions about KEPRO's Atrezzo Connect Provider Portal may contact KePRO by email at atrezzoissues@kepro.com. For service authorization questions, providers may contact KePRO at providerissues@kepro.com. KePRO can also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

KePRO will also accept requests by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. Specific information regarding the service authorization requirements and methods of submission may be found on the contractor's website at <https://dmas.kepro.com>.

OUT-OF-STATE PROVIDER INFORMATION

Effective March 1, 2013, there is a change in the policy and procedure for out-of-state requests submitted by out-of-state providers. This change impacts out-of-state providers who submit Virginia Medicaid service authorization requests to Keystone Peer Review Organization (KEPRO), DMAS' service authorization contractor, and any other entity to include, but not limited to, DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) when providing service authorizations for the services listed in the DMAS memo dated February 6, 2013 and titled "*Notification of a Procedural*

Change for Out-of-state Providers Submitting Requests for Service Authorization Through KEPRO".

KEPRO's service authorization process for certain services will include determining if the submitting provider is considered an out-of-state provider. Out-of-state providers are defined as those providers that are either physically outside the borders of the Commonwealth of Virginia or do not provide year end cost settlement reports to DMAS. Please refer to the above referenced DMAS memo dated February 6, 2013. Additional information is provided below.

Specific Information for Out-of-State Providers

Out-of-state providers are held to the same service authorization processing rules as in state providers and must be enrolled with Virginia Medicaid prior to submitting a request for out-of-state services to KEPRO. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to KEPRO, as timeliness of the request will be considered in the review process. KEPRO will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled.

If KEPRO receives the information in response to the pend for the provider's enrollment from the newly enrolled provider within the 12 business days, the request will then continue through the review process and a final determination will be made on the service request.

If the request was pending for no provider enrollment and KEPRO does not receive the information to complete the processing of the request within the 12 business days, KEPRO will reject the request back to the provider, as the service authorization cannot be entered into MMIS without the provider's National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request.

Out-of-state providers may enroll with Virginia Medicaid by going to <https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment>. At the toolbar at the top of the page, click on *Provider Services* and then *Provider Enrollment* in the drop down box. It may take up to 10 business days to become a Virginia participating provider.

Out-of-State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers. Procedures and/or services may be performed out-of-state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period.

Services provided out-of-state for circumstances other than these specified reasons shall not be covered:

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical

services, or necessary supplementary resources, are more readily available in the other state;

4. It is the general practice for recipients in a particular locality to use medical resources in another state.

The provider needs to determine which item 1 through 4 is satisfied at the time of the request to the Contractor. If the provider is unable to establish one of the four, the Contractor will:

- Pend the request utilizing established provider pend timeframes
- Have the provider research and support one of the items above and submit back to the Contractor their findings

“Effective September 12, 2016, KEPRO added additional questions to the out-of-state provider questionnaire (found on the Provider Portal):

- a. Question #2 - If the medical services are needed, will the recipient’s health be endangered if required to travel to state of residence? If a provider answers “Yes”, then additional question #2.1.1 asks: “Please explain the medical reason why the member cannot travel.”
- b. Question #5 - “In what state is the provider rendering the service and/or delivering the item physically located?”
- c. Question #6 - “In what state will this service be performed?”
- d. Question #7 - “Can this service be provided by a provider in the state of

Virginia? If a provider answers “No”, then additional question #7.2.1 asks: “Please provide justification to explain why the item/service cannot be provided in Virginia.”

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied using ARC 3110. This decision is also supported by 12VAC30-10120 and 42 CFR 431.52.

Medicaid Expansion

On January 1, 2019 Medicaid expansion became effective. Individuals eligible for

Medicaid expansion are:

- Adults ages 19-64,
- Not Medicare eligible,
- Not already eligible for a mandatory coverage group,
- Income from 0% - 138% Federal Poverty Level (FPL), and
- Individuals who are 100% - 138% FPL with insurance from the Marketplace. The new expansion aid categories:

Aid Category	Description
AC 100	Caretaker Adult, Less than or equal to 100% of the Federal Poverty Level (FPL) and greater than LIFC
AC 101	Caretaker Adult, Greater than 100% FPL
AC 102	Childless Adult, Less than 100% FPL
AC 103	Childless Adult, Greater than 100% FPL
AC 106	Presumptive Eligible Adults Less than or equal to 133% FPL
AC 108	Incarcerated Adults

The Medicaid Expansion Benefit Plan includes the following services:

Covered Service
Doctor, hospital and emergency room services
Prescription drugs
Laboratory and x-ray
Maternity and newborn care
Behavioral health services including addiction and recovery treatment
Rehabilitative and habilitative services including physical, occupational, and speech therapies and equipment
Family planning
Transportation to appointments
Home Health
DME and supplies
Long Term Support Services (LTSS) to include Nursing Facility, PACE and Home and
Community Based Service
Preventive and wellness
Chronic disease management

Premium assistance for the purchase of employer-sponsored health insurance coverage, if cost effective
Referrals for job training, education and job placement

All of the services currently submitted and reviewed by KEPRO remain the same. There are no new expansion benefits that require service authorization by KEPRO.

GAP Supplement

INTRODUCTION

Beginning January 12, 2015, the Department of Medical Assistance Services (DMAS) will begin a two-year, state wide §1115 demonstration waiver, the *Virginia Governor's Access Plan for the Seriously Mentally Ill (GAP)*. Virginia will offer a limited yet targeted package of benefits for individuals who have a serious mental illness (SMI) (as set out by DMAS) and incomes below 100% of the Federal Poverty Level.

The benefit package builds on a successful model of using existing partnerships to provide and integrate basic medical and behavioral health care services. This will enable individuals in the GAP Program to have coordinated access to those services, thereby enhancing treatment and increasing the potential to significantly reduce the severity of their symptoms. The three key goals of this Demonstration are to:

1. Improve access to health care for a segment of the uninsured population in Virginia who have significant behavioral and medical needs;
2. Improve health and behavioral health outcomes of demonstration participants; and,
3. Serve as a bridge to closing the insurance coverage gap for uninsured Virginians.

Services are provided through the existing Medicaid fee-for-service provider networks, and DMAS is continuing to use the service authorization processes currently used for the Medicaid and CHIP/FAMIS programs. DMAS already maintains a strong partnership with Magellan which serves as the Behavioral Health Services Administrator (BHSA) that performs service authorization, claims payment and provider credentialing and enrollment for behavioral health services. With expertise with this population, Magellan is the leading partner in Virginia for behavioral health service network management, service authorization, and claims payment.

GAP covered medical services are billed using the existing Medicaid fee-for-service process and paid at the current fee-for-service Medicaid/CHIP reimbursement rates. Some medical services will require authorization which is performed by the current service authorization contractor, Keystone Peer Review Organization (KEPRO). All benefits and terms of payment (as described in later sections) are specified in a contract document that will be executed with existing partners.

ELIGIBILITY AND ENROLLMENT

The GAP Program targets individuals who meet eligibility parameters resulting from a determination of being seriously mentally ill (SMI). In order to be eligible, individuals must meet ALL of the requirements outlined below, which are reviewed and verified by Cover Virginia.

- Adult ages 21 through 64 years old;
- U. S. Citizen or lawfully residing immigrant;
- Not eligible for any state or federal full benefits health insurance program including, but not necessarily limited to: Medicaid, Children's Health Insurance Program (CHIP/FAMIS), Medicare, or TriCare Federal Military benefits;
- Resident of Virginia;
- Household income that is below 95% of the Federal Poverty Level (FPL) plus a 5% income disregard;
- Uninsured;
- Not residing in a long term care facility, mental health facility, or penal institution; and
- Screened and meet the criteria for GAP SMI.

GAP eligibility determination has two parts; (i) a determination of whether or not the individual meets the GAP SMI criteria, and (ii) a determination of whether or not the individual meets the GAP financial and non-financial eligibility criteria. Individuals may start at either step to enter the GAP Program.

There are two ways to submit an application for GAP to Cover Virginia:

1. Individuals may contact the Cover Virginia GAP Unit telephonically by calling 1-855-869-8190 or TDD line at 1-888-221-1590. Applicants who apply at the GAP

Unit and have not had a GAP SMI Screening will be referred to the nearest screening entity to determine if the applicant meets the GAP SMI criteria. Applicants do not need to wait for the financial/non-financial information to be reviewed prior to being referred for the SMI screening.

Or

2. Through the provider assisted web portal accessed through a secure log in provided to the GAP SMI Screening Entity. Individuals may only be assisted by a GAP screening entity or another DMAS approved organization. The GAP SMI screening entities are: Community Services Boards (CSBs), Federally Qualified Health Centers (FQHCs), or hospitals with an inpatient psychiatric unit. This is the preferred method for application.

All applicants will receive a GAP SMI screening in the same manner and consideration without regard to financial or other non-age related eligibility criteria.

GAP SMI criteria is determined via the use of the GAP Serious Mental Illness Screening Tool (DMAS-P-603) which is completed by a DMAS approved GAP screening entity (see Screening Tool in “Exhibits”). The screening tool addresses 5 areas: age, diagnosis, duration of illness, level of disability, and whether due to mental illness the individual requires assistance to consistently access and utilize needed medical and/or behavioral health services/supports.

One of the two screening types listed below must be completed by a DMAS approved screening entity in order to determine GAP SMI eligibility.

1. **Limited Screening:** Conducted for individuals who have had a diagnostic evaluation completed by a Licensed Mental Health Professional (LMHP) (including Supervisees and Residents) within the past 12 months and this evaluation is available to the

screeners. The GAP SMI Screening Tool (DMAS-P-603) may be completed by either an LMHP (including Supervisees and Residents), Qualified Mental Health Professional-Adult (QMHP-A), or QMHP-Eligible (E). The available evaluation is submitted to Magellan as the required attachment along with the signed and dated DMAS-P-603 form.

As a rule, these screenings should be conducted face-to-face because the preferred process includes the screening entity assisting the individual with the application to Cover VA. (Completion via telemedicine is also acceptable.) SMI screenings may however be submitted on behalf of the individual without a face-to-face when all of the following are met:

- The individual has an open and active case with the screening entity;
 - The screening entity has the permission of the individual to submit a GAP SMI Screening; and
 - There is a mental health diagnostic evaluation on file that was completed by an LMHP (including supervisees and residents) within the past 12 months.
2. **Full Screening:** Conducted for individuals who have not had a diagnostic evaluation completed by an LMHP (including Supervisees and Residents) within the past 12 months or for whom the evaluation is not available to the screener. The signed and dated GAP SMI Screening Tool (DMAS-P-603) and diagnostic evaluation conducted at the time of the screening must be completed by an LMHP (including Supervisees and Residents) and submitted to Magellan. Full screenings must be completed face-to-face. (Completion via telemedicine is also acceptable.)

Provider qualifications for LMHP, LMHP-Supervisees/Residents, QMHP-A, and QMHP-E are located in Chapter II of the Community Mental Health Rehabilitative Services (CMHRS) Manual under “Provider Credentials for Mental Health Services” and 12VAC30-135-410.

GAP SMI Screenings must be conducted within 7 business days from the date of the individual’s request for screening or referral from Cover Virginia.

GAP SMI Screening Tools and required attachments are to be submitted to Magellan within

three business days of completion for an accuracy review. Magellan will have three business days to determine that the attachments support the items checked on the GAP SMI Screening Tool. GAP SMI screeners are to submit the DMAS-P-603 and required attachments to Magellan regardless of the screener's determined SMI outcome. Once reviewed Magellan will submit the GAP SMI met/not met decision to Cover Virginia in a nightly file.

All GAP applications will be determined no later than 45 days from the date of the application except in cases of unusual circumstances such as administrative or other emergency beyond the agency's control or an incomplete application which can be held open for 30 calendar days to enable applicants to provide outstanding information. Approval/Denial/Deficiency notices of action for eligibility will be sent out the next business day. Appeal rights information will be included on the notice. Eligible applicants will be enrolled in the MMIS system immediately upon determination and in the Magellan system no later than one week following the addition to MMIS.

Applicants who meet both the GAP SMI and financial/non-financial criteria will receive coverage effective on the first day of the same month in which the individual's signed application was received by Cover Virginia, with the exception of applications received in January 2015. For applications received in January 2015 coverage will begin the date that DMAS receives federal approval to begin the GAP demonstration waiver. No retroactive eligibility prior to the application month will be permitted in the GAP demonstration waiver program.

Individuals meeting the eligibility requirements for the GAP program will be enrolled for a period of 12 continuous months except if the individual becomes 65 years of age, moves out of the Commonwealth, or becomes enrolled in Medicare or Medicaid coverage.

The renewal of an individual's eligibility for the GAP program will be reviewed prior to the end of the 12-month coverage period. An additional determination of GAP SMI will not be required to complete the renewal for program eligibility.

VIRGINIA MEDICAID EXPANSION-EFFECTIVE JANUARY 1, 2019

On June 7, 2018, Governor Northam signed the 2018 Virginia Acts of Assembly Chapter 2 (2018 Appropriations Act) authorizing the Department of Medical Assistance Services

(DMAS) to amend Virginia's Medicaid State Plan to expand coverage to newly eligible non-disabled, non-pregnant adults ages 19 to 64 with income up to 138 percent of the FPL, effective on January 1, 2019. Because there will be an expanded Medicaid program, the Commonwealth no longer require the GAP program.

Most GAP members will be enrolled automatically into this new program January 1, 2019, if they have remained eligible and current in the GAP program through December 15, 2018. Unfortunately, due to federal eligibility requirements, only a very small number of GAP members will not be eligible for the new program. The GAP program for the individuals who are not eligible for the Medicaid Expansion program will be ending March 31, 2019.

Eligibility Card

An eligibility card with both the Virginia and GAP logo is issued to individuals to present at the time of service with participating providers. The provider is obligated to determine that the person to whom care or service is being rendered is the same individual listed on the eligibility card. The provider has the responsibility to request such identification as he or she deems necessary. Presentation of the GAP eligibility card is not proof of coverage nor guarantee of payment. A sample of a GAP eligibility card is included under "Exhibits" at the end of this supplement.

Eligibility for GAP benefits must be confirmed each time a service is rendered. The provider must determine if the service is within the dates of eligibility. Benefits are available only for services performed during the indicated period of eligibility. These dates must be checked prior to rendering any service.

Note: GAP benefits will not pay for care or services rendered before the beginning date or after the end date of eligibility.

GAP Coverage Co-payments

There are no premiums, copayments, coinsurance, or deductible charged to individuals who have been found to be eligible for the GAP program.

Additional information regarding Medicaid eligibility is located in Chapter III of the provider manual associated with each covered service.

COVERED SERVICES AND LIMITATIONS

GAP coverage is limited to outpatient medical, behavioral health, pharmacy, GAP case management, and care coordination services for individuals meeting the GAP SMI eligibility criteria. This program intends that such services will significantly decrease the severity of individuals' SMI so that they can recover, work, parent, learn, and participate more fully in their communities.

A complete benefits chart is located in the exhibits section of this supplemental manual.

Telemedicine

DMAS reimburses for telemedicine services under limited circumstances. Telemedicine is the real-time or near real-time exchange of information for diagnosing and treating medical conditions. Telemedicine utilizes audio/video connections linking medical practitioners in one locality with medical practitioners in another locality. DMAS recognizes telemedicine as a means for delivering some covered Medicaid services. Please refer to the Virginia Medicaid Memo dated May 13, 2014 — Updates to Telemedicine Coverage.

For telemedicine billing codes, refer to Chapter V of the Physician Manual. Questions may be emailed to DMAS at: Vatelmed@dmass.state.va.us.

SERVICES PROVIDED BY MAGELLAN

Care Coordination

Care coordination includes identification of the individual's behavioral health, medical and social/community support needs and the development, implementation, monitoring, and revision (as necessary) of a plan of care to efficiently achieve the individual outcomes in the most cost-effective manner. Care coordination has two main goals: 1) to improve the health and wellness of individuals with complex and special needs; and 2) to integrate services around the needs of the individual at the local level by working collaboratively with all partners, including the individual, family and providers. Care managers will provide information regarding:

- Covered benefits;
- Provider selection; and
- How to access all services including behavioral health and medical and use of preferred pathways to indigent medical and behavioral health services.

Magellan care managers work closely with local CSBs who are providing GAP case management services in order to assist GAP members in accessing needed medical, psychiatric, pharmacy, and other supports as appropriate. The following are among the interventions provided for individuals as part of Care Coordination:

- Member Handbook
- Access to toll-free number 24 hours a day, seven days a week
- Web-based and e-learning material
- Online health literacy materials
- Self-help groups and community-based support groups where available
- Linkages and referrals to community resources
- Recovery Navigation Services where available
- Parent and family support
- Collaborative Treatment Planning

Members may initiate care coordination with or without the assistance of another provider. Individuals are not required to obtain other GAP benefits in order to utilize care coordination and may contact a care manager at 1-800-424-4279 or 1-800-424-GAP9.

Care coordination services through Magellan include two tiers, Community Wellness and Community Connection. These tiers are to optimize the physical, social and mental functioning of individuals by: increasing community tenure, reducing readmissions, enhancing support systems, and improving treatment efficacy through advocacy, communication, and resource management.

Community Wellness (Tier One)

Individuals at this level require the least amount of care coordination. Generally, their needs can be met through short-term assistance from Magellan staff for issues such as

follow-up from a crisis call, help in finding a specialty provider, coordination and follow-up with the individual's case manager, or linking to behavioral health services. Magellan will contact and coordinate care with the local CSB and other providers. If the individual has any co-occurring medical and behavioral health conditions Magellan will oversee and monitor the communication and collaboration between the physical health and behavioral health providers to ensure an integrated treatment program for the individual. The goal of this level of support is to solidify the individual's connection with providers, the CSB, and resources for continued care, as well as improve community participation and better understanding and focus on achieving overall wellness.

Community Connection (Tier Two)

This level of support is designed for individuals with higher level of need, such as those with frequent emergency room visits and hospitalization discharges with high social stressors suggesting a possible risk for hospital readmission. Interventions for these individuals combine technological and clinical resources to enable ongoing participation in treatment. Care coordination services for individuals in the Community Connection level is led by assigned care managers. The average length of support at this level is from 3 to 12 weeks. The minimum contact requirement for Community Connection is a minimum of twice per month. The acuity of the individual's presentation will guide the timeframe and frequency of contacts and interventions.

Crisis Line

Magellan care managers are all licensed mental health professionals. Care managers are available to GAP members 24 hours per day, 7 days per week in case of behavioral health crisis situations. Care managers coordinate with local CSB's crisis intervention teams as well as local law enforcement to assist with the provision of mental health care for acute psychiatric dysfunction requiring immediate clinical attention. The objectives are to prevent exacerbation of a condition and prevent injury to the individual or others until additional services can be administered. Care managers can be reached at 800-424-4279 or 800-424-GAP9.

Recovery Navigation Services

Recovery Navigation services are provided through Magellan. Magellan Recovery Navigation Services are provided by trained Recovery Navigators, who self-disclose as living with or having lived with a behavioral health condition. The goal of Recovery Navigation Services is to make the transition back into the community a successful one and avoid future

psychiatric inpatient hospital stays by providing an array of linkages to peer run services, natural supports, and other recovery oriented resources.

Face-to-face recovery navigation services will be available in select areas of the state in which there are a high concentration of peer-run community organizations. It is expected that there will be more frequent face-to-face engagement via the recovery navigation team compared to clinical team members. These voluntary services are designed to facilitate connections with local peer-run organizations, self-help groups, other natural supports, and to engage individuals in treatment with the appropriate community-based resources to prevent readmission, improve community tenure and meaningful participation in the community of their choice.

A state wide warm-line telephonic recovery navigation resource is available as part of the Recovery Navigation Service. The warm-line is staffed by Recovery Navigators who have specific training to provide telephonic support. It offers extended hours and toll-free access at 1-800-424-4520.

Other recovery navigation services include, but are not limited to:

- Describing and developing a plan for engaging in peer and natural community support resources as part of the recovery process.
- Visiting individuals in inpatient settings to develop the peer relationship.
- Exploring peer and natural community support resources from the perspective of a person who has utilized these resources and navigated multi-level systems of care. These linkages will expand to educating members about organizations and resources beyond the health care systems.
- Initiating rapport, teaching and modeling positive communication skills with

individuals to help them self-advocate for an individualized services plan and assisting the individual with the coordination of services to promotes successful community integration strategies.

- Assisting in developing strategies to decrease or avoid the need for future hospitalizations by offering social and emotional support and an array of individualized services.
- Providing social, emotional and other supports framed around the eight dimensions of wellness:
 - **Emotional**—Coping effectively with life and creating satisfying relationships
 - **Environmental**—Good health by occupying pleasant, stimulating environments that support well-being
 - **Financial**—Satisfaction with current and future financial situations
 - **Intellectual**—Recognizing creative abilities and finding ways to expand knowledge and skills
 - **Occupational**—Personal satisfaction and enrichment from one's work
 - **Physical**—Recognizing the need for physical activity, healthy foods and sleep
 - **Social**—Developing a sense of connection, belonging, and a well-developed support system
 - **Spiritual**—Expanding our sense of purpose and meaning in life

Some recovery navigation services are currently only available in select areas of the state due to limited resources. For information on what supports are offered in your area you may contact Magellan at 1-800-424-4279 or 1-800-GAP9.

Recovery navigation services are not currently reimbursed by DMAS and are only available for GAP members through Magellan.

MEDICAL SERVICES

The limited GAP medical services such as outpatient physician and clinic services, specialist, diagnostic procedures, laboratory procedures, and pharmacy services are covered in the exact same manner as Medicaid. The GAP benefit plan includes limited medical services

that require service authorization through DMAS' Service Authorization Contractor, Keystone Peer Review Organization (KEPRO) or the DMAS Medical Support Unit (Please see Appendix D of the Physician Practitioner Manual.). Providers should refer to current manual appendixes, DMAS Medicaid Memos, and the KEPRO or DMAS website for service authorization details since timeliness applies as with current processes.

All services covered in the GAP program must be billed and reimbursed through the existing fee-for-service methodology and claims process.

A complete benefits guide is included in the "Exhibits" section of this supplemental manual.

Outpatient Physician Services and Medical Office Visits, Clinic Services, Specialty Care, Consultation, and Treatment

GAP covered services include evaluation and management, diagnostic and treatment procedures performed in the physician's office, and medically necessary therapeutic or diagnostic injections.

Information pertaining to provider participation requirements, coverage and limitations, billing, utilization review and control, and service authorization for outpatient physician services and medical office visits, clinic services, specialty care, consultation, diagnostic, and treatment is located in the Physician/Practitioner Manual Chapters II, IV, V, VI, Appendix B, and Appendix D.

Please see the list of non-covered services at the end of this supplement to ensure the service being offered is not a non-covered service.

Outpatient Diagnostic Services

Outpatient diagnostic services includes ultrasound, electrocardiogram, service-authorized CAT, MRI scans and all diagnostic services that can be performed in a physician's office

with the exception of colonoscopy procedures and other services listed as non-covered.

Information pertaining to provider participation requirements, coverage and limitations, billing, utilization review and control, and service authorization for outpatient physician services and medical office visits, clinic services, specialty care, consultation, diagnostic, and treatment is located in the Physician/Practitioner Manual Chapters II, IV, V, VI, and Appendix D.

Please see the list of non-covered services at the end of this supplement to ensure the service being offered is not a non-covered service.

Outpatient Laboratory and Radiology Services

Information pertaining to provider participation requirements, coverage and limitations, billing, utilization review and control, and service authorization for outpatient laboratory is located in the Independent Laboratory Manual Chapters II, IV, V, VI, and Appendix C.

Please see the list of non-covered services at the end of this supplement to ensure the service being offered is not a non-covered service.

Outpatient Hospital Services

Outpatient hospital procedures are limited to:

- diagnostic ultrasound procedures;
- EKG/ECG including stress tests; and
- radiology procedures unless otherwise listed as a non-covered service.

Information pertaining to provider participation requirements, coverage and limitations, billing, utilization review and control, and service authorization for outpatient hospital coverage is located in the Hospital Manual Chapters II, IV, V, VI, and Appendix D.

Please see the list of non-covered services at the end of this supplement to ensure the service being offered is not a non-covered service.

Information related to Temporary Detention Orders is located in Appendix B of the Hospital Manual.

Outpatient Pharmacy

Information pertaining to provider participation requirements, coverage and limitations, billing, utilization review and control, and drug utilization review for Outpatient Pharmacy is located in the Pharmacy Manual Chapters II, IV, V, VI, and VII.

Please see the list of non-covered services at the end of this supplement to ensure the service being offered is not a non-covered service.

Outpatient Medical Equipment and Supplies

Outpatient medical equipment and supplies are limited to certain diabetic equipment and supply services. Please see the list of non-covered services at the end of this supplement to ensure the service being offered is not a non-covered service.

Information pertaining to coverage and limitations, billing, utilization review and control, and service authorization for outpatient medical equipment and supplies is located in the Physician/Practitioner Manual Chapters IV, V, VI, and Appendix D. Information is also located in the Durable Medical Equipment & Supplies Manual Chapters II, IV, V, VI, and Appendix B8.

BEHAVIORAL HEALTH SERVICES

All behavioral health services covered in the GAP program must be billed and reimbursed through the existing Magellan Behavioral Health of Virginia methodology and claims process unless specifically stated as otherwise.

GAP Case Management (H0023 UB & UC Modifiers)

GAP Case Management (GCM) is provided statewide by CSB case managers with consultation and support from Magellan care managers and does not include the provision of direct services. Services are targeted to individuals who are expected to benefit from assistance with medication management, and appropriate use of community resources. It is a two tiered service with the provision of either regular or high intensity case management and is focused on assisting individuals with accessing needed medical, behavioral health (psychiatric and substance abuse treatment), social, education, vocational, and other support services.

Service Definition

GCM services are designed to assist individuals in solving problems, if any, accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs, including:

- assessment and planning services, including developing an individual service plan(ISP) (does not include performing medical and psychiatric assessment but does include referral for such assessment);
- linking the individual to services and supports specified in the ISP;
- assisting the individual face-to-face for the purpose of locating, developing or obtaining needed services and resources;
- coordinating services and service planning with other agencies and providers involved with the individual;
- enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community livings skills, and use vocational, civic, and recreational services;
- making collateral contacts with the individuals' key contacts to promote implementation of the service plan and community adjustment;
- follow-up and monitoring to assess ongoing progress and to ensure services are delivered; and
- education and counseling which guides the individual and develops a supportive

relationship that promotes the service plan.

Eligibility Criteria

The individual must meet the GAP criteria of having a serious mental illness and be actively enrolled in the GAP demonstration waiver.

- The individual must require case management as documented on the ISP, which is developed by a qualified GAP case manager and based on an appropriate assessment and supporting documentation.
- An ISP must be in effect which requires regular direct or individual-related contacts and communication or activity with the individual, family, service providers, and/or other key contacts.

Required Activities

- A comprehensive assessment must be completed by a qualified GAP case manager within the first month of the GCM service to determine the need for services. A qualified GAP case manager must meet all of the knowledge, skills, and abilities as a mental health case manager as set out in Chapter II of the Community Mental Health Rehabilitative Services (CMHRS) Manual.
- The GAP case management assessment does not require a service registration.
- GCM assessment and planning services, to include developing an ISP (does not include performing medical and psychiatric assessments, but does include referral for such).
- The GCM must notify the primary care provider (PCP) of the individual's receipt of GAP case management. Notification can be provided via telephone or written contact to the PCP office. In the event an individual does not have a PCP at the time of the GCM assessment the GAP case manager must document efforts by the case manager

and individual to locate one. Monthly progress notes must reflect these efforts. Should the individual be unwilling to obtain a PCP, progress notes should reflect ongoing efforts by the case manager in encouraging the individual to incorporate physical wellness and medical checkups into their overall treatment plan.

- The ISP must document the need for GCM and must be fully completed within 30 calendar days of the initiation of the service. The comprehensive assessment must be completed prior to the development of the ISP.
- The GCM shall review the ISP monthly and document that the ISP has been reviewed. The review must be completed by the last day of the month following the month in which the last review was completed.
- GAP case management contact, activity, or communication must be relevant to the ISP. Written plan development, review, or other written work is not a reimbursable GCM activity.
- The GAP case management entity and Magellan must have monthly contact for care coordination activities.
- Linking the individual to needed services and supports specified in the ISP.
- Coordinating services and treatment planning with other agencies and providers.
- Making collateral contacts with key contacts to promote implementation of the service plan.
- Monitoring service delivery as needed through contacts with service providers.

- Education and counseling which guide the individual and develop a supportive relationship that promotes the service plan. Counseling in this context is not psychological counseling, examination, or therapy. The case management counseling is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's functional capacity in the community. These activities must be linked to the goals and objectives on the case management ISP.
- The GAP case manager may provide education and counseling activities in a group session if the material presented was specifically chosen and designed to meet the identified medical and/or behavioral health needs of the individual and was listed as a specific strategy in the individual's ISP.
- Case management services are intended to be an individualized client-specific activity between the case manager and the individual. There are some appropriate instances where the case manager could offer case management to more than one individual at a time. The provider bears the burden of proof in establishing that the case management activity provided simultaneously to two or more individuals was individual-specific. For example, the case manager needs to work with two individuals, each of whom needs assistance applying for housing benefits. The case manager may work with both individuals simultaneously for the purpose of helping each individual obtain benefits and subsequently follow-up with each individual to ensure that he or she has proceeded correctly.
- A face-to-face contact must be made at least once every 90 days. The purpose of the face-to-face contact is for the case manager to observe the individual's condition, to verify that services which the case manager is monitoring are being provided, to assess the individual's satisfaction with services, to determine any unmet needs, and to generally evaluate the individual's status.

GAP case management services include assistance to GAP participants with finding providers for services, applying for needed community services, and face-to-face interactions to ensure that participants remain engaged in the GAP.

Service Pathways

GAP offers basic coverage for medical and behavioral services, including pharmacy, to individuals who meet the GAP SMI criteria. Many of these individuals are currently served collectively through the indigent care pathways, including through CSBs, the FQHCs, hospitals, the free clinics, and other providers that service indigent populations. Case managers are expected to use already established indigent behavioral health and medical care providers, in addition to existing resources in the individual's life to help them toward better health outcomes and an improved quality of life.

GAP beneficiaries may choose their own providers. GAP case managers may assist with providing the individual with information so that the individual may make an informed choice; for example, these providers are on the bus line, these providers can provide bubble packs for your medication, etc. The individual may either stay with the indigent care provider or select a GAP provider.

Magellan is available to assist the GAP individual or case manager with identifying behavioral health providers. This can be done via the Magellan website provider search at www.magellanoftexas.com or by contacting Magellan by phone. Magellan will also know of other behavioral health services the individual may already have a service authorization for or if they have had an authorization with another provider at some point previously and refer the individual to that service or provider.

Additionally Magellan is available to assist the GAP case manager to identify medical health care providers. The GAP case manager may contact Magellan who has access to the DMAS VAMMIS system which will identify Medicaid enrolled health care providers in the locality of the GAP member. Contact information for the local providers will be provided to the GAP case manager who then links/refers the individual to an appropriate provider. GAP members may also contact Magellan for information by calling 1-800-424-4279 or 1-800-424-GAP9.

The GCM may also contact Magellan to inquire as to whether there are any medical or pharmacy claims for the individual in order to help determine whether the individual is keeping PCP or specialist appointments, picking up medications from the pharmacy, obtaining diabetic supplies, etc.

Service Units and Maximum Service Limitations

- Regular intensity GCM shall be billed if the minimum required activities of active GAP case management have been met.
- High Intensity GCM shall be billed for any month in which the regular intensity GCM requirements have been met AND there is a face-to-face contact with the individual during that month that takes place in a community setting outside of the case management office.
- GCM reimbursement rates are as follows:

1 Unit = 1 Calendar month

Regular Intensity GCM (H0023, UB modifier) - \$195.90 per unit

High Intensity GCM (H0023, UC modifier) - \$220.90 per unit

- Urban and rural rates do not apply for GCM
- A billing unit is one calendar month.
- Billing can be submitted for GAP case management only for months in which direct or client-related contacts, activity, or communications occur. These activities must be documented in the clinical record. The provider should bill for the specific date of the activity or the date the monthly summary note has been documented.
- In order to support the 1 billing unit per calendar month for high intensity GCM, the face to face visit must be performed on the date billed or the specific date the

monthly summary note is completed, AND there must be contacts made and documented within that same month. In order to bill for regular intensity GCM, required activities and contacts must occur during the month and be appropriately documented as previously referenced. Providers are NOT to span the month for GAP CM services.

- Reimbursement shall be provided only for "active" case management individuals. An active individual for GAP case management shall mean an individual for whom there is a current ISP that requires regular direct or client-related contacts or activity or communication with the individual or families, key contacts, service providers, or others. Billing can be submitted only for months in which direct or individual-related contacts, activity or communications occur.
- Federal regulation 42CFR441.18 prohibits providers from using case management services to restrict access to other services. An individual cannot be compelled to receive case management if he or she is receiving another service, nor can an individual be required to receive another service if they are receiving case management. For example, a provider cannot require that an individual receive case management if the individual also receives medication management services.
- No other type of case management, from any funding source, may be billed concurrently with GAP case management.
- Reimbursement for GAP case management services for individuals in Institutions for Mental Disease (IMD) is not allowed. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds.
- There is no maximum service limit for case management services except case management services for individuals residing in institutions or medical facilities. Case management services may not be provided for institutionalized individuals. Services rendered during the time the individual is not admitted to the IMD may be billed, even if during the same month as the admission to the IMD.
- To bill for case management services for individuals that are in an acute care

inpatient psychiatric units, two conditions must be met. The services may not duplicate the services of the hospital discharge planner, and the community case management services provided to the individual are limited to one month of service, 30 days prior to discharge from the facility. Case management for hospitalized individuals may be billed for no more than two non-consecutive pre-discharge periods in 12 months.

- Case management services for the same individual must be billed by only ONE type of case management provider.

Service Registration

While service authorization for GAP Case Management is not required, registration of this service with Magellan is required.

Registration is a means of notifying Magellan that an individual will be receiving GAP case management services, thereby avoiding duplication of services and ensuring informed care coordination. Providers should register the start of GAP Case Management within two (2) business days of the service start date.

Registration may occur electronically, by phone or fax. Required elements to provide Magellan include: (1) the individual's name and GAP identification number; (ii) the specific service to be provided, the relevant procedure code and modifier, begin date of the service, and the amount of the service that will be provided; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address.

Case Management Agency Requirements

1. The service specific provider intake and subsequent re-assessments of the individual's medical, mental, and social status must be reflected with appropriate documentation. The initial comprehensive service specific provider intake must also include current documentation of a medical examination, a psychological/psychiatric evaluation, and a social assessment.

2. All ISPs (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state laws, whichever is longer. The individual or legal representative must sign the ISP.
3. There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the individual (or parent or guardian when appropriate) sign a document verifying freedom of choice of providers was offered and this provider was chosen.
4. A release form must be completed and signed by the individual for the release of any information.
5. Case management records must include the individual's name, dates of service, name of the provider, nature of the services provided, achievement of stated goals, if the individual declined services, and a timeline for reevaluation of the plan. There must be documentation that notes all contacts made by the case manager related to the ISP and the individual's needs.

Psychosocial Rehabilitation (H2017)

All information pertaining to provider qualifications, service definition, eligibility criteria, required activities, limitations, discharge criteria, billing, utilization review, and service authorization for Crisis Stabilization Services is located in the Community Mental Health Rehabilitative Services (CMHRS) Manual Chapters II, IV, V, VI, and Appendix C.

Service Registration through Magellan is required for Psychosocial Rehabilitation Services.

Crisis Intervention (H0036)

Crisis intervention services shall only be rendered by a Licensed Mental Health Professional (LMHP), LMHP-supervisee, LMHP-resident, LMHP-Resident in Psychology, or a certified pre-screener.

Unless otherwise specified above all additional information pertaining to provider qualifications, service definitions, eligibility criteria, required activities, limitations, discharge criteria, billing, utilization review, and service registration for Crisis Intervention is located in the Community Mental Health Rehabilitative Services (CMHRS) Manual Chapters II, IV, V, VI, and Appendix C.

Service Registration is required for Crisis Intervention.

Crisis Stabilization (H2019)

All information pertaining to provider qualifications, service definition, eligibility criteria, required activities, limitations, discharge criteria, billing, utilization review, and service authorization for Crisis Stabilization Services is located in the Community Mental Health Rehabilitative Services (CMHRS) Manual Chapters II, IV, V, VI, and Appendix C.

Service Authorization through Magellan is required for Crisis Stabilization for individuals enrolled in GAP.

ADDICTION RECOVERY AND TREATMENT SERVICES (ARTS)

On April 1, 2017, Virginia's Medicaid program launched an enhanced substance use disorder treatment benefit - **Addiction and Recovery Treatment Services (ARTS)**. The ARTS benefit provides treatment for those with substance use disorders across the state. The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, FAMIS, FAMIS MOMS and the Governor's Access Plan (GAP), including expanded community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment.

For GAP, the following chart reflects the ARTS services covered by GAP:

Service/Level of Care	Manual Reference	Differences in GAP
Screening Brief Intervention and Referral to Treatment (ASAM Level 0.5)	Addiction Recovery and Treatment Services (ARTS) Manuals Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Opioid Treatment Services (ASAM Level OTS)	Addiction Recovery and Treatment Services (ARTS) Manuals Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Office Based Opioid Treatment (OBOT)	Addiction Recovery and Treatment Services (ARTS) Manuals Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Outpatient Services (ASAM Level 1)	Addiction Recovery and Treatment Services (ARTS) Manuals Chapters II, IV, V, VI, and Appendix A	Follows ARTS coverage
Intensive Outpatient Services (ASAM Level 2.1)	Addiction Recovery and Treatment Services (ARTS) Manuals Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Partial Hospitalization Services (ASAM Level 2.5)	Addiction and Recovery Treatment Services (ARTS) Manual Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Clinically Managed Low Intensity Residential Services (ASAM Level 3.1)	Addiction and Recovery Treatment Services (ARTS) Manual Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Clinically Managed Population-Specific High Intensity Residential Services (ASAM Level 3.3)	Addiction and Recovery Treatment Services (ARTS) Manual Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Clinically Managed High-Intensity Residential Services (Adult) (ASAM Level 3.5)	Addiction and Recovery Treatment Services (ARTS) Manual Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Medically monitored intensive inpatient services (Adult) (ASAM Level 3.7)	Addiction and Recovery Treatment Services (ARTS) Manual Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage

Addiction and Recovery Treatment Services (ARTS) Peer Support Services	Addiction and Recovery Treatment Services (ARTS) Manual Chapters II, IV, V, VI, and Appendix A.	If a GAP enrollee elects to transition out of Recovery Navigation services through BHSA and receive MH Peer Support Services, the BHSA recovery navigator should assist with the transition from BHSA-provided peer support navigation. The transition period may last up to 30 consecutive calendar days and address discharging from recovery navigator services and engagement in peer support services.
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Peer Support Services

The provision of Peer Support Services facilitates recovery from serious mental illnesses and/or substance use disorders. Peer Support Services are an evidence-based mental health model of care in which a qualified peer support provider assists individuals with their recovery from mental health and substance use disorders. Recovery is a process in which individuals are able to live, work, learn and fully participate in their communities. Peer Support Services will be delivered by peers who have been successful in the recovery process, and can extend the reach of treatment beyond the clinical setting into an individual's community to support and assist continued engagement in the recovery process. The experiences of peer support providers are an important component in the delivery of a comprehensive mental health and substance use services. GAP started covering Peer Support services July 1, 2017.

The Peer Support Services policy manual is published as a Supplement to the appropriate DMAS Provider Manuals including Addiction and Recovery Treatment Services (ARTS), Community Mental Health and Rehabilitation Services (CMHRS), Residential Treatment Services, Psychiatric Services, and Hospital Provider manuals and can be located on the provider portal.

NOTE: If a GAP enrollee elects to transition out of Peer Navigation Services through the BHSA and receive MH or ARTS Peer Support Services, the BHSA peer support navigator shall assist with the transition from BHSA-provided peer support navigation. The transition period may last up to 30 consecutive calendar days and address discharging from recovery navigator services and engagement in peer support services.

Psychiatric Evaluation and Outpatient Therapy

Outpatient psychotherapy services shall be covered consistent with limitations and requirements outlined in the Psychiatric Services Manual. Psychiatric evaluation and outpatient individual, family, and group therapies for mental health and ARTS are covered under GAP.

Additional information pertaining to provider qualifications, service definitions, eligibility criteria, required activities, limitations, discharge criteria, billing, utilization review, and service authorization for psychiatric evaluation and outpatient therapy can be found in the Psychiatric Services Manual Chapters II, IV, V, VI, and Appendix C and the ARTS Manual.

Service limits outlined in the Psychiatric Services Manual pertaining to the number of yearly visits do not apply to individuals enrolled in GAP. There are no maximum benefit limitations on traditional behavioral health psychotherapy services; however service authorization following the first 26 visits in the first year after benefits are obtained is required.

Reimbursement shall be provided in a tiered manner for physicians, psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, and licensed clinical nurse specialists-psychiatric consistent with 12VAC30-80-30(A)(3).

Please see the list of non-covered services at the end of this supplement to ensure the service being offered is not a non-covered service.

NOTIFICATION REQUIREMENTS

Whenever an adverse action is taken, the individual receiving services must receive written

notification of the pending action at least 10 days before the effective date of the action, except for the following:

1. Advance notice will be reduced to five days if the facts indicate the action is necessary because of probable fraud; and
2. Advance notice does not need to be sent if:
 - The individual has stated in writing that he or she no longer wishes to receive GAP services;
 - The individual gives information that requires the termination of GAP, and the member knows that this action is the result of giving the information;
 - The individual has been admitted to an institution where he or she is ineligible for services under GAP;
 - The individual moves to another state; or
 - The individual's whereabouts are unknown. The agency will determine that the individual's whereabouts are unknown if mail sent to the member is returned as undeliverable.

NON-COVERED SERVICES

The following is a list of services that are not covered by GAP:

Non-covered Medical Services

- Any medical service not otherwise defined as covered in Virginia's State Plan for Medical Assistance Services.

- Chemotherapy
- Colonoscopy
- Cosmetic procedures
- Dental
- Dialysis
- Durable medical equipment (DME) and supply items (other than those required to treat diabetes)
- Early and Periodic Screening Diagnosis and Treatment (EPSDT) services
- Emergency room treatment
- Hearing aids
- Home health (including home IV therapy)
- Hospice
- Inpatient treatment
- Long-term care including home and community based waiver services, custodial care facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Nutritional supplements
- OB/maternity care including birthing centers (gynecology services are covered)
- Orthotics and prosthetics
- Outpatient hospital procedures (other than the following diagnostic procedures)
 - Diagnostic ultrasound procedures
 - EKG/ECG, including stress
 - Radiology procedures (excludes PET and Radiation Treatment procedures)
 - PT, OT, and speech therapies
- Private duty nursing
- Radiation therapy
- Routine eye exams (to include contact lenses and eyeglasses)
- Services from non-enrolled Medicaid providers
- Services not deemed medically necessary
- Services that are considered experimental or investigational
- Sterilization (vasectomy or tubal ligation)
- Transportation - emergency and non-emergency

Non-covered Behavioral Health Services

- Any behavioral health or substance use treatment services not otherwise defined as covered in Virginia's State Plan for Medical Assistance Services
- Day treatment partial hospitalization
- Electroconvulsive therapy and related services (anesthesia, hospital charges, etc.)
- Emergency room services
- EPSDT services including multi-systemic ABA treatment
- Hospital observation services

- Intensive in-home services
- Intensive community treatment (PACT)
- Inpatient hospital or partial hospital services
- Mental health skill-building services
- Psychological and neurophysiological testing
- Residential treatment services (Level A, B and C)
- Services specifically excluded under the State Plan for Medical Assistance
- Services not deemed medically necessary
- Services that are considered experimental or investigational
- Services from non-enrolled Medicaid providers
- Smoking and tobacco cessation and counseling
- Therapeutic day treatment
- Treatment foster care case management (TFC-CM)
- Transportation - emergency and non-emergency
- VICAP assessments

PROVIDER APPEALS

The DMAS Appeals Division maintains an appeal process for enrolled GAP providers of GAP services who have rendered services and are requesting to challenge an adverse decision. The appeal process is available to (i) enrolled GAP service providers that have rendered services and have received a denial in whole or part for GAP covered services, and (ii) enrolled GAP service providers who have received a Notice of Program Reimbursement or overpayment demand from DMAS or its contractors.

Unless otherwise specified above, department provider appeals shall be conducted in accordance with DMAS provider appeal regulations at 12VAC30-20-500 *et. seq.*, the Code of Virginia at §32.1-325 *et. seq.*, and the Virginia Administrative Process Act §2.2-4000 *et. seq.*

Providers shall not have the right to appeal this GAP program's loss of funding and subsequent denial of services for all applicable individuals.

A notice of appeal is considered filed when it is date stamped by the DMAS Appeals

Division. The notice must identify the issues being appealed. Notices of appeal must be sent to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street, 6th Floor

Richmond, VA 23219

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely.

CLIENT APPEALS

The Code of Federal Regulations at 42 CFR §431, Subpart E, the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370, and 12VAC-30-135-487 through 12VAC30-135-495 require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid client or by an authorized representative on behalf of the client. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the client may be expected to repay DMAS for all services received during the appeal period. For this reason, the client may choose not to receive continued services. The entity that took action (Cover Virginia or the service authorization contractor) will be notified by DMAS to reinstate services if continuation of services is applicable. If services are continued or reinstated due to an appeal, they must continue until a decision is rendered by the hearing officer.

Appeals must be requested in writing and postmarked or submitted within 30 days of

receipt of the notice of adverse action. The client or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

The appeal request must be signed and mailed to the:

Appeals Division

Department of Medical Assistance Services

600 E. Broad Street

Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 452-5454

The Appeals Division will notify clients of the date, time and location of the appeal hearing if the appeal is valid and a hearing is granted. The hearing will be conducted by a DMAS hearing officer. Most hearings will be done by telephone.

The hearing officer's decision is the final administrative decision by DMAS. If the client does not agree with the hearing officer's decision, he/she may appeal it directly to the Circuit Court in the city or county of residence.

SOURCES OF INFORMATION

General questions regarding the GAP program and regulatory interpretation may be submitted to DMAS via e-mail at BridgetheGAP@dmas.virginia.gov. For specific questions pertaining to services and billing providers are encouraged to contact:

- **Magellan Behavioral Health of Virginia**

Providers of behavioral health services may check GAP member eligibility, behavioral health claims status, behavioral health check status, behavioral health service limits, and behavioral health service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or TDD 1-800-424-4048 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

- **Keystone Peer Review Organization (KEPRO)**

For medical service authorization questions, providers may contact KEPRO at providerissues@kepro.com. KEPRO may also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

KEPRO's website has information related to the service authorization process for all Medicaid programs that they review. Fax forms, service authorization checklists, trainings, methods of submission and much more are on KEPRO's website. Providers may access this information by going to <http://dmas.kepro.com>.

- **Virginia Medicaid Web Portal**

DMAS offers a web-based Internet option to access **medical and pharmacy** information GAP member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays.

The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

• **Medical and Pharmacy “Helpline”**

The DMAS “HELPLINE” is available to answer medical and pharmacy questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The “HELPLINE” numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the “HELPLINE” is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

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